Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 13, 2023

Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

RE: CCN: 245475
Cycle Start Date: April 12, 2023

Dear Administrator:

On May 16, 2023, we notified you a remedy was imposed. On May 12, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 26, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective NO DATA be discontinued as of May 26, 2023. (42 CFR 488.417 (b))

- Discretionary denial of payment for new Medicare and Medicaid admissions effective NO DATA did not go into effect. (42 CFR 488.417 (b))

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 12, 2023 be discontinued as of May 26, 2023. (42 CFR 488.417 (b))

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 12, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 16, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 12, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 26, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 13, 2023

Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

Re: Reinspection Results
Event ID: I9QI12

Dear Administrator:

On May 12, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 12, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 20, 2023

Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

RE: CCN: 245475
Cycle Start Date: April 12, 2023

Dear Administrator:

On April 12, 2023, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 July 12, 2023, (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 October 12, 2023, (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/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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 20, 2023

Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

Re: State Nursing Home Licensing Orders
Event ID: I9QI11

Dear Administrator:

The above facility was surveyed on April 11, 2023, through April 12, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00543	A. BUILDING: _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

(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 4/11/23 and 4/12/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed. H54751115C (MN00092568) with a licensing orders issued at 0565 and 1545. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		4/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21545	Continued From page 3 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to administer anticoagulant medication (blood thinning) per physician orders for 1 of 2 residents (R1) reviewed for medication errors. Findings include: R1's quarterly Minimum Data Set (MDS) dated 2/15/23, diagnoses included chronic atrial fibrillation (irregular heartbeat that can result in blood clot formation). R1 had intact cognition. R 1 was administered anticoagulant medication seven out of seven days. R1's care plan identified R1 had a history of stroke with interventions dated 11/15/22, that directed staff to obtain labs and administer medications per physician orders. R1's physician orders included the following orders: -2/6/23 Coumadin 2.5 milligrams (mg) by mouth	21545	CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

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21545	Continued From page 4 Monday and Friday until 3/3/23 -2/6/23 Coumadin 5 mg by mouth Tuesday, Wednesday, Thursday, Saturday, and Sunday until 3/5/23 -4/6/23 Coumadin 5 mg by mouth now -4/8/23 Coumadin 2.5 mg by mouth Monday and Thursday until 4/12/23 R1's physician orders did not identify an order for Coumadin after 3/5/23. R1's March 2023 medication administration record (MAR) identified R1 did not receive Coumadin from 3/6/23 to 4/5/23. The MAR identified R1 did not receive the next dose of Coumadin until 4/6/23, when the one time dose of 5 mg was ordered. In review of R1's record, it was not evident R1 had an international normalized ratio (INR- lab that measures viscosity of blood) completed in March that would be used to determine R1's Coumadin dosing after the order stop date of 3/5/23. R1's INR lab results dated 4/6/23, identified R1's INR was 0.9; R1's goal was 2-3 (per interview with physician on 4/12/23) During an interview on 4/11/23 at 3:30 p.m. Registered Nurse (RN)-A, indicated the facility was responsible for checking resident's INR's (ordered by the anticoagulation clinic) at the facility using their machine. The nurse would send the results via fax to the clinic and would then receive a telephone order. The clinic would then give a verbal order for the Coumadin dose along with the date to draw the INR. The nurse would then transcribe those verbal orders into the electronic health record (EHR), which produced a	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

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21545	Continued From page 5 paper copy of the order. The paper copy would then be faxed to the physician to sign the orders. when they were ordered by the anticoagulation clinic. The nurse would then mark the INR on the calendar at the nurse's station. During an interview on 4/11/23, at 5:41 p.m. director of nursing (DON) reviewed R1's record, DON confirmed R1 did not receive Coumadin between 3/6 and 4/6/23. DON expected nursing to follow the facility policy for anticoagulation management. Further expected nursing to double check orders for accuracy. During an interview on 4/11/23 at 5:10 p.m. medical doctor (MD)-A stated R1 required Coumadin to prevent stroke. MD-A explained missing the Coumadin for a month was significant but not remarkably serious as sometimes we need to take patients off Coumadin for procedures. R1's goal for her INR was 2-3, her results on 4/6/23 was 0.9. MD-A's stated expectation that staff follow the orders of providers and providers be informed of any significant medication error immediately by phone so immediate interventions could be placed. During an interview on 4/12/23 at 12:50 p.m. medical director (MD-B) stated that it was his expectation that orders are followed through on as the provider ordered them. MD-B also stated the with Coumadin is a significant medication error and needed to be followed up on immediately. Facility Anticoagulation Therapy policy, dated 11/28/18, included: 3. Monitor routine INR levels a. Report all levels to physician/Anti-Coagulation Clinic and hold medication until level is assess	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21545	Continued From page 6 and new orders are received. Procedure: 1. All Coumadin orders will be processed promptly, with two licensed nurses verifying and signing for the order 2. Once an INR is checked, the licensed nurse will document the results on a lab referral form and fax this to the physician or Anticoagulation Center 3. The nurse(s) processing the order will ensure the following tasks are completed: a. new order must be documented on physician order form, lab referral form, and communication for and/or telephone order form. b. all pertinent information will be recorded on the Anticoagulation Flow Sheet located in the INR binder located in the nurses' station. c. the new order will be entered into PCC (electronic medical record), with a second nurse verifying the order for correctness. d. a stop date will be put on the new order which will be the date the next INR check is scheduled for e. all Coumadin orders must be entered with the specific dose listed. f. the date of the next INR check will be entered on the calendar at the nurses' station and will also be entered as a treatment in PCC. g. the new order will be faxed to the resident's pharmacy. h. All Coumadin orders will be entered as new orders. i. all portions of Coumadin orders will be verified and signed for by two licensed nurses. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21545	Continued From page 7 and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

(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 4/11/23 and 4/12/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H54751115C (MN00092568) with a deficiency issued at F760. 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 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to administer anticoagulant medication (blood thinning) per physician orders for 1 of 2 residents (R1) reviewed for medication errors. Findings include:	F 760	The deficiency for the 1 resident affected was corrected on 4/11, as Director of Nursing (DON) received telephone orders for an INR check, completed the INR check, updated the Medical Director with INR result, Medical Director provided verbal orders to DON for coumadin	4/28/23

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

Electronically Signed | 04/28/2023

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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	245475	A. BUILDING _____ B. WING _____	C 04/12/2023

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F 760	Continued From page 1 R1's quarterly Minimum Data Set (MDS) dated 2/15/23, diagnoses included chronic atrial fibrillation (irregular heartbeat that can result in blood clot formation). R1 had intact cognition. R 1 was administered anticoagulant medication seven out of seven days. R1's care plan identified R1 had a history of stroke with interventions dated 11/15/22, that directed staff to obtain labs and administer medications per physician orders. R1's physician orders included the following orders: -2/6/23 Coumadin 2.5 milligrams (mg) by mouth Monday and Friday until 3/3/23 -2/6/23 Coumadin 5 mg by mouth Tuesday, Wednesday, Thursday, Saturday, and Sunday until 3/5/23 -4/6/23 Coumadin 5 mg by mouth now -4/8/23 Coumadin 2.5 mg by mouth Monday and Thursday until 4/12/23 R1's physician orders did not identify an order for Coumadin after 3/5/23. R1's March 2023 medication administration record (MAR) identified R1 did not receive Coumadin from 3/6/23 to 4/5/23. The MAR identified R1 did not receive the next dose of Coumadin until 4/6/23, when the one time dose of 5 mg was ordered. In review of R1's record, it was not evident R1 had an international normalized ratio (INR- lab that measures viscosity of blood) completed in March that would be used to determine R1's Coumadin dosing after the order stop date of	F 760	dosing. No other residents are currently on coumadin in the facility. Another resident at the time of deficiency on coumadin was discharged on 4/21/23 to home. Initiated after the initial coumadin error on 4/6/23 was identified. Weekly auditing will be ongoing for all coumadin orders for current and future residents. Results will be reviewed at the Quality Assurance committee to ensure compliance. The Coumadin Clinic has changed their practice to now send a written copy of the order after they have received a new INR for residents receiving coumadin. The anticoagulation policy was updated to reflect the changes on 04/27/23. Nurses were provided a copy of the policy on 04/28/23. A copy was also provided in the nurses communication book in the nurses station. Education will be provided at the nurses meeting on May 3, 2023, reviewing the anticoagulation policy.	

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F 760	Continued From page 2 3/5/23. R1's INR lab results dated 4/6/23, identified R1's INR was 0.9; R1's goal was 2-3 (per interview with physician on 4/12/23) During an interview on 4/11/23 at 3:30 p.m. Registered Nurse (RN)-A, indicated the facility was responsible for checking resident's INR's (ordered by the anticoagulation clinic) at the facility using their machine. The nurse would send the results via fax to the clinic and would then receive a telephone order. The clinic would then give a verbal order for the Coumadin dose along with the date to draw the INR. The nurse would then transcribe those verbal orders into the electronic health record (EHR), which produced a paper copy of the order. The paper copy would then be faxed to the physician to sign the orders. when they were ordered by the anticoagulation clinic. The nurse would then mark the INR on the calendar at the nurse's station. During an interview on 4/11/23, at 5:41 p.m. director of nursing (DON) reviewed R1's record, DON confirmed R1 did not receive Coumadin between 3/6 and 4/6/23. DON expected nursing to follow the facility policy for anticoagulation management. Further expected nursing to double check orders for accuracy. During an interview on 4/11/23 at 5:10 p.m. medical doctor (MD)-A stated R1 required Coumadin to prevent stroke. MD-A explained missing the Coumadin for a month was significant but not remarkably serious as sometimes we need to take patients off Coumadin for procedures. R1's INR goal was 2-3, her results on 4/6/23 was 0.9. MD-A's stated expectation that	F 760		

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F 760	Continued From page 3	F 760		

staff follow the orders of providers and providers be informed of any significant medication error immediately by phone so immediate interventions could be placed.

During an interview on 4/12/23 at 12:50 p.m. medical director (MD-B) stated that it was his expectation that orders are followed as ordered. MD-B reported Coumadin was a significant medication error and needed to be followed up on immediately.

Facility Anticoagulation Therapy policy, dated 11/28/18, included:
3. Monitor routine INR levels
a. Report all levels to physician/Anti-Coagulation Clinic and hold medication until level is assess and new orders are received.
Procedure:
1. All Coumadin orders will be processed promptly, with two licensed nurses verifying and signing for the order
2. Once an INR is checked, the licensed nurse will document the results on a lab referral form and fax this to the physician or Anticoagulation Center
3. The nurse(s) processing the order will ensure the following tasks are completed:
a. new order must be documented on physician order form, lab referral form, and communication for and/or telephone order form.
b. all pertinent information will be recorded on the Anticoagulation Flow Sheet located in the INR binder located in the nurses' station.
c. the new order will be entered into PCC (electronic medical record), with a second nurse verifying the order for correctness.
d. a stop date will be put on the new order which will be the date the next INR check is

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F 760	Continued From page 4 scheduled for e. all Coumadin orders must be entered with the specific dose listed. f. the date of the next INR check will be entered on the calendar at the nurses' station and will also be entered as a treatment in PCC. g. the new order will be faxed to the resident's pharmacy. h. All Coumadin orders will be entered as new orders. i. all portions of Coumadin orders will be verified and signed for by two licensed nurses.	F 760		