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 Therefore, the NATCEP prohibition is rescinded.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

May 16, 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 20, 2023, we informed you that we may impose enforcement remedies.

On May 2, 2023, the Minnesota Department(s) of Health 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 July 12, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 12, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 12, 2023.

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 $11,292, 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 July 12, 2023 the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Parkview Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 12, 2023. 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" and/or an "E"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 October 12, 2023 (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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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,

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

May 16, 2023

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

Re: Event ID: 2FMW11

Dear Administrator:

The above facility survey was completed on May 2, 2023 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,

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

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 05/02/2023

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 4/28/23 and 5/2/23, 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 complaint was reviewed: H54751762C (MN92902) with a deficiency issued at F600. As a result of the investigation, additional deficiencies were cited at F609 and 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		5/26/23

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

Electronically Signed | 05/23/2023

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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F 600	Continued From page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify and implement interventions to ensure 2 of 2 residents (R2, R3) were free of physical abuse by 1 of 1 residents (R1), who was noted to have an increase in physical behaviors. Findings include: R1's quarterly Minimal Data Set (MDS) dated 3/16/23, indicated R1 had a diagnosis of developmental disorder of scholastic skills (learning disability) and did not exhibit behaviors. R1's Order Summary dated 5/3/23, indicated R1 had a nursing order to monitor for verbal aggression and physical aggression towards wandering residents and intervene as needed which was started on 4/13/23. R1's care plan revised 3/31/23, indicated R1 was at risk for decline in behavior related to history of stroke and R1 could be impatient, impulsive, and socially inappropriate at times. R1's care plan directed staff to try to be in the vicinity when he	F 600	F600- The facility took the following actions for the identified residents. This affected 2 residents and has the potential to affect all residents. R1 is now eating in his room, and he is being served first. There have been no further incidents of aggression. Upon interviewing R1 he stated the change is good and is better this way. He also stated there was no one to bother him. R1□s care plan initiated on 04/19 was revised on 4/28/23 to include the goal of not harming self or others. This includes the interventions of analysis of trigger and documenting behaviors. Intervening when agitation escalates. Requested orders for speech therapy to evaluate for cognitive changes. Communication was provided to nursing assistant staff on how to view residents care plans Kardex. The team did a root cause analysis and took the following actions to improve the process of communicating interventions to the entire team. A root cause analysis will	

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F 600	Continued From page 2 was around other residents as he tends to become protective of certain areas. R1's care plan for physically aggressive behaviors towards other residents related to impulse control which was revised as of 4/28/23 (survey entrance date), with interventions that included: analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document; provide physical and verbal cue to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out a staff member when agitated; monitor while in the dining room area; when the resident becomes agitated intervene before escalates, guide away from source of distress, engage calmly in conversation, reapproach. R2's admission MDS dated 4/17/23, indicated R1 had a diagnosis of dementia and had impaired cognition. R2 would exhibit wandering behavior. R3's quarterly MDS dated 1/25/23, indicated R3 had a diagnosis of Alzheimer's Disease and had moderately impaired cognition. R3 exhibited physical aggression, rejection of care and wandering behaviors. During continuous observation on 5/2/23, from 11:27 a.m. until 11:44 a.m. R1 was in the dining room sitting at a table independently and appeared to be reading a book. There were no staff within visual sight of R1 and there were several other residents noted to be in the dining room, including R2. During an interview on 4/28/23, at 1:46 p.m. licensed practical nurse (LPN)-A indicated care plan revisions and interventions are	F 600	be done by the IDT team members at 10 am daily following an incident, until a solution is reached. This intervention will be communicated to all staff members through communication and education. The facility will monitor by completing audits of staff members after an intervention has been implemented to assure awareness and compliance. The Date of Correction is 05/26/23.	

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F 600	Continued From page 3 communicated to the staff by shift change report as well as communication sheets in the nurses' office. LPN-A indicated R1 exhibited physical and verbal behaviors, and R1 would often become irritable related to residents who wander and get into R1's space. LPN-A indicated on 4/19/23, she was called to the dining room and upon arrival R2 was on the floor and R1 was standing behind him. LPN-A stated R1 appeared worried and began pacing back and worth "like he knew he did something wrong". Further, LPN-A indicated R1's physical aggression was new, and staff were directed to chart and monitor R1's behaviors and LPN-A was not aware of any additional interventions. During an interview on 4/28/23, at 2:42 p.m. dietary manager (DM) stated R1 had a history of being possessive about the dining room and not wanting other residents in the dining room when R1 was in there. DM stated as he exited the kitchen and was walking back to his office, he had noticed R1 pushing R2 aggressively in R2's wheelchair out of the dining room and mumbling words when R2 fell forward out of his wheelchair onto the floor. During an interview on 4/28/23, at 3:15 p.m. nursing assistant (NA)-A indicated care plan revisions with new interventions are communicated through verbal report and the communication book in the nurses' office. During an interview on 5/2/23, at 9:01 a.m. NA-B indicated care plan revisions and new interventions were communicated through verbal report at the start of each shift, however NA-B was unaware if the facility had a communication book or if the NA's had access to each resident's	F 600		

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F 600	Continued From page 4 care plan. NA-B indicated she was aware R1 and R2's incident but was not aware of any interventions or increased monitoring of R1. During an interview on 5/2/23, at 9:17 a.m. NA-C indicated R1 had a temper and exhibited verbal and physical aggression. NA-C indicated R1 would become possessive of the dining room and did not like other residents in the dining room when he was in there. NA-C indicated those behaviors appeared to be increased during the evening hours. Further, NA-C indicated R1's behavioral interventions included staff educating R1 on appropriate behavior, which was ineffective, and having the more vulnerable residents closer to staff in the dining room. During an interview on 5/2/23, social services designee (SSD) indicated prior to the incident involving R1 and R2, SSD indicated staff were expected to supervise the dining room area if R1 was in the dining room, which was implemented due to a previous altercation with another resident, to protect other vulnerable residents and prevent future altercations with R1. SSD indicated following R1 and R2's incident she contacted the Ombudsman to assist with an appropriate intervention for R1's behaviors, as well as had R1's family, doctor, and the police spoke with R1 regarding inappropriate behavior. Further, SSD was unsure what interventions were to be implemented following the incident. During an interview on 5/2/23, at 11:54 a.m. director of nursing (DON) indicated care plan revisions including new interventions were communicated to staff by DON writing a note in the communication nook that is kept in each break room as well as the nurses' office wall.	F 600		

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F 600	Continued From page 5 When asked about R1's care plan intervention that was initiated on 3/31/23, directing staff to "try to be in the vicinity when he is around other residents" DON stated she was unaware of that specific intervention and was not sure what staff were expected to do as the direction was "vague". Further, DON confirmed on 4/28/23, after surveyor entered the facility, DON revised R1's care plan and implemented behavior interventions to address R1's physical behaviors. DON indicated R1's care plan was updated on 4/28/23, directing staff to closely monitor and supervise R1 while he is in the dining room. DON confirmed staff were not educated on R1's behavior interventions. During an interview on 5/2/23, at 1:51 p.m. administrator indicated she completed the investigation for R1 and R2's incident and as an intervention the Ombudsman was contacted for suggestions on interventions for R1's behaviors as well as increased monitoring and being aware of R1's location however, administrator was not aware if staff received education on R1's care plan revisions. Review of facility policy titled Abuse, Neglect and Exploitation, not dated, indicated the facility will make efforts to ensure all residents are protected from physical harm during and after the investigation which could include but are not limited to: increased supervision of the alleged victim and residents.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		5/26/23

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F 609	Continued From page 6 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 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 the findings of the investigation to the State Agency (SA) within 5 working days for 2 of 3 residents (R1, R2) following a resident-to-resident physical abuse allegation. Findings include: R1's quarterly Minimal Data Set (MDS) dated 3/16/23, indicated R1 was cognitively intact and	F 609	F609- The facility took the following actions that have the potential to affect all residents. Administrator will ensure email verification from OHFC is received. The administrator will share the verification with Director of Nursing (DON) and Management company representative. The Date of Correction is 05/26/23.	

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 05/02/2023

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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F 609	Continued From page 7 did not exhibit any behaviors. R2's admission MDS dated 4/17/23, indicated R1 had a diagnosis of dementia and had impaired cognition. R2 would exhibit wandering behavior. On 4/28/23, at approximately 1:00 p.m. surveyor requested a copy of facility's 5-day investigation report. Review of facility report number 352030 dated 4/19/23, to the SA indicated R1 "shoved" R2 which caused R2 to fall forward out of their wheelchair and onto their knees, however no injury was noted. Review of facility report dated 4/28/23 at 1:36 p.m. was submitted to the SA with the findings of the investigation. During an interview on 5/2/23, at 11:54 a.m. director of nursing (DON) indicated facility was required to report investigation follow-up to the SA within 5 working days, however the administrator was waiting for DON to review prior to submitting and thought they submitted but had not. During an interview on 5/2/23 at 1:51 p.m. administrator indicated facility was required to report the investigation follow-up to the SA within 5 working days, but the incident with R1 and R2 had not been submitted until the surveyor requested a copy on 4/28/23. Administrator indicated the investigation for the incident was completed on 4/26/23, however administrator did not realize there was an error and did not submit on 4/26/23. Administrator indicated she had no evidence of the error message saved.	F 609		

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F 609	Continued From page 8 Review of facility policy titled Abuse, Neglect, and Exploitation Policy, not dated, indicated the administrator or designee will report the results of the investigation when final within 5 working days of the incident.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 complete a thorough investigation for 2 of 3 residents (R1, R2) following a resident-to resident physical abuse allegation. Findings include: R1's quarterly Minimal Data Set (MDS) dated 3/16/23, indicated R1 was cognitively intact and did not exhibit any behaviors.	F 610	F610 The facility took the following actions for the identified residents. This affected 2 residents and had the potential to affect all the residents. The facility did a root cause analysis and took the following actions to improve the process of investigations. The facility will complete an RCA with IDT team daily at 10 am following each incident to identify	5/26/23

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F 610	Continued From page 9 R1's care plan revised on 3/31/23, directed staff to "try to be in the vicinity when he is around other residents. He tends to become overprotective of 'his areas' as he perceives them." R2's admission MDS dated 4/17/23, indicated R1 had a diagnosis of dementia and had impaired cognition. R2 would exhibit wandering behavior. Review of facility report number 352030 dated 4/19/23, to the SA indicated R1 "shoved" R2 which caused R2 to fall forward out of their wheelchair and onto their knees, however no injury was noted. During an interview on 5/2/23, at 11:54 a.m. director of nursing (DON) indicated she did not participate in the investigation for this incident. During an interview on 5/2/23, at 1:51 p.m. administrator indicated they completed the investigation for the incident that occurred on 4/19/23, between R1 and R2. Administrator indicated as part of the investigation she interviewed the witness and the licensed nurse that completed the assessment following the incident but did not obtain any other interviews from nursing staff that were working with R1 or R2 on 4/19/23. Further, administrator confirmed she did not review R1's care plan as part of the investigation and was unaware R1's care plan was not followed at the time the incident occurred as no direct care staff were in the vicinity of R1 to visually keep an eye on him. Administrator indicated the root cause of the incident was determined to be R1 did not want people in the dining room.	F 610	what to investigate. The IDT team will also identify who is responsible for each part of the investigation. Facility will use this information to help formulate an intervention plan. The Date of Correction is 05/26/23.	

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F 610	Continued From page 10 Review of facility policy titled Abuse, Neglect and Exploitation, undated, indicated when suspicion of abuse occur an immediate investigation is warranted and the investigation includes identifying and interviewing all involved persons and others who might have knowledge of the allegations, and determining if abuse has occurred, the extent, and cause.	F 610		

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	00543	A. BUILDING: _____ B. WING _____	C 05/02/2023

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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 4/28/23 and 5/2/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure	2 000		

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2 000	Continued From page 1 The following complaint was reviewed during the survey: H54751762C (MN92902). 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		