

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 17, 2021

Administrator Parkview Manor Nursing Home 308 Sherman Avenue Ellsworth, MN 56129

RE: CCN: 245553 Cycle Start Date: January 27, 2021

Dear Administrator:

On January 27, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

Parkview Manor Nursing Home February 17, 2021 Page 2

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Parkview Manor Nursing Home February 17, 2021 Page 3

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 April 27, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 27, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates

Parkview Manor Nursing Home February 17, 2021 Page 4 specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 17, 2021

Administrator Parkview Manor Nursing Home 308 Sherman Avenue Ellsworth, MN 56129

Re: State Nursing Home Licensing Orders Event ID: 3TCX11

Dear Administrator:

The above facility was surveyed on January 25, 2021 through January 27, 2021 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 <u>only a suggestion</u> 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

Parkview Manor Nursing Home February 17, 2021 Page 2 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:

Susie Haben, Unit Supervisor St. Cloud B District Office Licensing and Certification Program 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

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

Please feel free to call me with any questions.

Sincerely,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00406	B. WING		01/2) 7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARKVI	EW MANOR NURSING	; HOME	MAN AVEN RTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	survey was conduct with State Licensurvey NOT in compliance Please indicate in y correction that you and identify the date	TS: 1/27/21, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 02/25/21

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 12

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00406	B. WING			27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
PARKVI	EW MANOR NURSING	G HOMF	RMAN AVENU DRTH, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	substantiated: H5553009C (MN00 issued. H5553010C (MN00 issued.	plaints were found to be 0069212) with licensing orders 0065168) with licensing orders plaint was found to be				
	unsubstantiated:	•				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." For	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and rrection.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.si obul.htm. The State delineated on the a Department of Hea you electronically.	in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ttached Minnesota Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00406	B. WING	01/	01/27/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PARKVIE	EW MANOR NURSING	3 HOME	RMAN AVEN RTH, MN 56			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	heading completion be corrected prior t the Minnesota Dep is enrolled in ePOC	ensure process, under the n date, the date your orders will o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			3/15/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident n bed.				
	by: Based on interview facility failed to ens assessed and imple staff were trained o	ent is not met as evidenced and document review, the ure interventions were emented to prevent falls and in medical equipment used for 1 of 3 residents (R3).		corrected		

STATEMEN	Ita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00406	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PARKVI	EW MANOR NURSING	3 HOME	RMAN AVENU			
,		ELLSWOI	RTH, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	nge 3	2 830			
	Findings include:					
	(MDS) identified R3 required extensive mobility, transfers, personal hygiene. F Stroke, hemiplegia right side, chronic p R3's care plan date fall risk due to havin affecting his right s have staff assist wi	rterly Minimum Data Set 3's cognition was intact. R3 assistance of one staff for bed ambulation, toileting, and R3's diagnoses included and hemiparesis affecting his bain, and encephalopathy. ed 1/27/21, identified R3 was a ng a fall history and stoke ide. Interventions include to th ambulation and transfers				
	were to ensure R3 keep the bed in the fall risk evaluations and as need. Staff appropriately to ens	by recommendations. Staff wore appropriate footwear, lowest position, and complete with each new fall, quarterly, were to use devices sure safety and place blue side of the bed when in bed.				
	the following: On 12/24/20 at 6:00 after the supper me belt, hemi-walker, a slipped and lost his was assisted to the	ment Reports (RMR) identified 0 p.m., R3 was being assisted eal to the rest room with a gait and assistance of 1 staff. R3 is footing on his right foot and floor by staff. R3 landed on ght arm. R3 had no injures at				
	notes all lacked evi	RMR, care plan and progress dence of any immediate /ere implemented as a result of				
		ress note identified R3 fell in an unidentified NA transferred				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION	COM	E SURVEY PLETED
		00406	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PARKVIE	EW MANOR NURSING	GHOME	ERMAN AVENU ORTH, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	•	-	2 830			
	him to the toilet. R3 paper dispenser.	3 hit his head on the toilet				
	was being transfer the fall. R3's Post-f of any immediate in	-fall Evaluation identified R3 red to the toilet at the time of fall Evaluation lacked evidence nterventions that were result of the 12/24/20 fall.)			
	assistant (NA)-B id assistance with tra ambulating. R3 had knee occasionally	21, at 10:00 a.m. with nursing lentified R3 required staff nsfers, toileting, and d right sided weakness, and hi buckles when ambulating. He to the floor a few times, but ill when.	s			
	identified R3 was fi the toilet and had b times due to dizzin	21, at 10:03 a.m. with (NA)-B requently dizzy when getting o been lowered to the floor many ess. Also R3's knee buckles he walks, and staff need to be	,			
	nurse (RN)-A ident a hemi walker and belt for ambulation hemiplegia on his r ambulate due to th He needed staff to his right arm. Staff on how to ambulate received any trainin	21, at 2:42 p.m., with registered tified R3 had a stroke and used assistance of 1 staff and a ga and to use the toilet. R3 had right side, and was tricky to e limited use of his right side. stabilize the right side under received written instructions e residents, but had not ng on how to use the hemi f were not as familiar with how	d			
	physical therapist (21, at 2:08 p.m. with the (PT) identified he had not hear 33 was admitted to the facility	d			

	ta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00406			01/	01/27/2021	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
PARKVI	EW MANOR NURSING	S HOME	RMAN AVENU DRTH, MN 561				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 5	2 830				
	hemi-walker and as belt. The PT expect fell, or had to be low be evaluated to see lowered him to the evaluation and also knew how to use the as hemi-walkers we other equipment. S to use the hemi wa but the restorative s appropriately use th	ad improved enough to use a ssistance of 1 staff and a gait ted to be updated if residents wered to the floor so they could a if PT was appropriate. If staff floor, PT would do an o observe staff to ensure they he hemi walker appropriately ere not used as frequently as taff were not educated on how lker when he was admitted, staff who were trained how to ne walker, would have been taff on how to use it					
	director of nursing of when staff lowered been contacted, an retrained on transfe techniques for R3 f no additional interve the falls to prevent management repor 8/17/20. Staff were implement interven to complete a fall re- section of the elect be reviewed by the The DON agreed, F should have been e to ensure R3 used	ollowing the falls. There were entions implemented following further falls. R3 had no risk t completed for the fall on to follow the policy and tions to prevent falls, and were eport in the Risk Management ronic medical records so it can interdisciplinary team (IDT). R3's falls during transfers evaluated and staff observed the hemi-walker and staff r support for R3 to ambulate					
	policy was to proteo safety. PT was to b	Prevention policy identified the ct residents and promote e informed of falls and was to when there were repeated					

If continuation sheet 6 of 12

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00406		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/27/2021		
						01/27/2021	
	PROVIDER OR SUPPLIER	308 SHE	DDRESS, CITY, S RMAN AVENU				
PARKVII	EW MANOR NURSING	3 HOME	ORTH, MN 561				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ige 6	2 830				
	resident experience the fall policy. Falls monthly, and during performance impro- management team pharmacist. Reside were to have more interventions imple SUGGESTED MET The director of nurs review/revise polici falls, accidents and proper assessment implemented and the of a change in cord staff on the policies for evaluating and the implementation of the developed, with the	THOD OF CORRECTION: sing or designee, could es and procedures related to resident supervision to assure t and interventioins are being ne provider is promptly notified dition. They could re-educate and procedures. A system monitoring consistent these policies could be results of these audits being ty's Quality Assurance	9				
21000	(21) days.	R CORRECTION: Twenty-one 0 Subp. 4 Dietary Staff iene.	21000			3/15/21	
	Subp. 4. Hygiene. wash their hands a their arms with soa washing facility bef as often as is nece after smoking, eatin handling soiled equ	Dietary staff must thoroughly nd the exposed portions of p and warm water in a hand ore starting work, during work ssary to keep them clean, and ng, drinking, using the toilet, or ipment or utensils. Dietary ir fingernails clean and					

If continuation sheet 7 of 12

Minnesc	ta Department of H	ealth			i oran	AITROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY
		00406	B. WING		C 01/27/2021	
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	-	
	PROVIDER OR SUPPLIER		RMAN AVEN			
PARKVII		GHOME	RTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21000	Continued From pa	age 7	21000			
	by: Based on observative served food in a set hand hygiene after surfaces while served food in a set hand hygiene after surfaces while serve facility failed to ensue surfaces were clear equipment to ensue sanitized. Findings include: Continued observative aid (DA)-A of the k a.m., identified the cracked tiles on the tiles missing, expo- mat at the dishwase two tiles were loos basin sink, tan driet bottom of the sink drying area identifit towards cups, and fan had debris adh of the microwave is bottom of the micro- stove identified the thick white debris of the bottom of the co- cabinet next to the along the side of the refrigerator identifier and upper the grill of the serving islam basin sitting in it. B	tion, interview, and document failed to ensure dietary staff anitary manner and performed contact with high touch ving meals. Additionally the sure kitchen equipment and aned regularly, and maintained re the kitchen was properly ation and interview with dietary itchen on 1/27/21 at 10:08 dishwashing room had four e floor with one and one half sing concrete under the rubber sher. At the triple basin sink, e and warped. In the triple ed debris was adhered to the basin. Observation of the dish ed a fan was blowing directly dishes air drying on racks. The pered to the guard. Observation dentified dried drippings on the owave door. Observation of the ed dip pan under the grill had with medium black particles on frip pan. The side of the pan grill had whitish-gray debris ne cabinet. Observation of the ed dried debris on the handles of the refrigerator. Observation didentified a sink with a black below the sink, two plastic		Corrected		
Minnesster		rk brown dried debris were				
winnesota D	epartment of Health					

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00406	B. WING		01/27/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PARKVI	EW MANOR NURSING	G HOMF	RMAN AVENU RTH, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21000	Continued From pa	ge 8 -trap drain. A strainer was in	21000			
	one of the plastic or chunky debris dried refrigerator identifie and upper grill of th she had worked at months and the tile started. The mainte tiles were missing. blower on the dishe identified there was	ontainers and had brown I to it. Observation of the ed dried debris on the handles e refrigerator. DA-A identified the facility for about two s had been like that since she enance department was aware She was unsure when the es was last cleaned. DA-A also a no cleaning schedule in ing staff was responsible for				
	Interview with Cook a.m., verified the ha microwave door, gr were not thoroughly not had a deep clea kitchen island sink used routinely, but staff could drain ca was washed daily in unsure who cleaned	(C)-A on 1/27/21, at 10:21 andles on the refrigerator, ill drip pan, and pan cabinet y cleaned. The kitchen had aning in the past year. The had a slow drain and was not the basin was in the sink so nned vegetables. The basin in the dishwasher. She was d the plastic containers under they have been like that for				
	quite some time. Ea kitchen, while in use clean all the handle end of the night. No presently in place, a at least October 20 dietary manager. S	a they have been like that for ach shift was to clean up the e, and the evening shift was to as and high touch areas at the o cleaning schedule were and had not been place since 20, when the facility had a new taff would clean the stove and y were able. C-A confirmed				
	the fan had debris i directly towards the unaware that the fa towards the dishes position at the facili had resigned about	n the guard, and was blowing drying dishes. She was n was not supposed to point . C-A had just resumed a ty during the past month, but t two months ago due to e dietary manager. Prior to				

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	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL		
		00406	B. WING		C 01/27/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
		308 SHE	RMAN AVENU	JE			
		ELLSWO	ORTH, MN 561	29			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21000	Continued From pa	age 9	21000				
	tiles had been crac she could remembe the tiles and the sir plan was to fix then communicate need maintenance depar does not represent old dietary manage and several staff ha manager. She only months, but the kito were not served ac menus because the food required to se many substitutions notify the dietitian of the menus. The kito cracks, and the sta manager were work practices. Kitchen s	ed in the kitchen, and the floor sked and missing for as long as er. Maintenance was aware of nk, she was unsure what the n staff used sticky notes to led repairs in the kitchen to the rtment. C-A stated the kitchen what the staff were like. The er was not able to do the job, ad quit during the time she was worked at the facility for a few chen was in bad shape. Menus cording to the dietitian's e manager would not order the rve the meals. Menus had , and the staff continued to of the concerns of not following chen had fallen through the off and new interim dietary king towards restoring kitchen sanitation had not yet been menus were now being					
	at 11:45 a.m., ident during the meal set commercial sandw with her gloved har refrigerator, opened condiments, and w washing her hands with her gloved har Interview on 12/27/	noon meal service on 1/27/21, tified C-A was wearing gloves rvice. C-A was serving turkey iches, and handled the bread nds. C-A walked to the d the refrigerator to get ithout removing her gloves and s, she continued to serve bread nds, and served up food trays. /21, at 12:25 p.m., with C-A ot removed her gloves and	ł				
	handles of the refri	giene after touching the door gerator. The handle had not ollowing observation of debris ed gloves should be removed					

ARKVIE		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00406		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		PLETED
ARKVIE			B. WING		01/2	27/2021
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	W MANOR NURSING	; HOME	RMAN AVENU RTH, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21000	Continued From pa	ge 10	21000			
		performed after contact with and before direct contact with lents.				
	identified prior to the the menus were no the menus. The old ordering food accor frequently ordered to ordered the food a the normal procedu dietary manager rol with orders until she process, but the die Staff were also not time between Octob 2021. The schedule or dietary aid sched	21, at 12:47 p.m., with C-B e old dietary manager leaving, t being followed according to dietary manager was not rding to the menu and the incorrect food. She had not week in advance as had been ire prior to her taking the e. Staff offered to assist her e was familiar with the etary manager refused help. scheduled correctly during the ber 2020, and mid January e would often not have a cook luled, and staff would have to shifts. Many staff resigned, under staffed.				
	dietitian identified the sanitation for a long have been trained if and a cleaning list wo one time there was kitchen staff, however manager deleted me vacating the position with the previous di follow-through, and the right person for confirmed the ment and staff alerted the substitutions being the first issue corre	20, at 2:18 p.m., with the ne facility had issues with it time. The kitchen staff should in kitchen sanitation upon hire, was expected to be in place. At a cleaning schedule for the ver one of the former dietary any documents prior to n. There were also concerns etary manager regarding that person was simply not the job. The dietitian us were not being followed, e dietitian of the many made. Following menus was cted after the dietary manger emove gloves and perform				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00406	B. WING			C 01/27/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
PARKVII	EW MANOR NURSING	G HOMF	RMAN AVENU PRTH, MN 561				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21000	Continued From pa	ge 11	21000				
	Kitchen equipment schedule and betwe kitchen was also to schedule to preven dietitian also agree serving island sink removed and any c maintain a sanitary department had ma needed updating. A kitchen sanitation not provided. The 3/4/20, Handw policy identified stat donning gloves, and use was not a repla hygiene. No policy specific for kitchen SUGGESTED MET The administrator, of designee could revi procedures related and kitchen sanitati of nursing, or desig educate staff and d ensure compliance findings to the Qual Improvement (QAP recommendations to	s and before serving food. was to be cleaned on a een meal services. The have a deep cleaning t food-borne illnesses. The d equipment such as the should be in working order or racked tiles replaced to environment. The dietary any outdated policies that a policy was requested, and ashing and Hand Hygiene ff were to wash hands before d after removing gloves. Glove acement for performing hand was provided for hand hygiene staff. THOD OF CORRECTION: director of nursing (DON) or iew and revise policies and to sanitation, food preparation ion. The administrator, director nee could develop a system to The facility could report those lity Assurance Performance PI) committee for further to ensure ongoing compliance. R CORRECTION: Twenty-one					

DEPAR	IMENT OF HEALTH	I AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	COM	E SURVEY IPLETED
		245553	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				30	08 SHERMAN AVENUE		
				E	LLSWORTH, MN 56129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F 0	00			
	survey was comple Minnesota Departm your facility was no requirements of 42	ugh 1/27/21, an abbreviated ted at your facility by the nent of Health to determine if t in compliance with CFR Part 483, Subpart B, and ong Term Care Facilities.					
	substantiated: H5553009C (MN00 cited at F808 and F	plaints were found to be 1069212) with deficiencies 1812 1065168) with deficiencies					
	The following comp unsubstantiated: H5553011C (MN00	plaint was found to be 1065637)					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 689	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with azards/Supervision/Devices	F 6	89			3/15/21
SS=D	CFR(s): 483.25(d)(§483.25(d) Accider The facility must er §483.25(d)(1) The	1)(2) hts. isure that - resident environment remains					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						02/25/2021

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

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		E & MEDICAID SERVICES	(X2) MU	TIPI			0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
						C	2	
		245553	B. WING			01/2	27/2021	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PARKVI	EW MANOR NURSING	G HOME			08 SHERMAN AVENUE LLSWORTH, MN 56129			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 689	Continued From pa	age 1	F 6	89				
	as free of accident	hazards as is possible; and						
	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced							
	by: Based on interview	w and document review, the sure interventions were			Fall policy to be reviewed and revise DON. A checklist will be developed f			
	assessed and impl staff were trained of	lemented to prevent falls and on medical equipment used for r 1 of 3 residents (R3).			charge nurses with step by step instructions on procedures to follow a fall occurs. The checklist will include			
	Findings include:				proper assessments, immediate interventions implemented to ensure resident's safety and to notify family			
	(MDS) identified R required extensive mobility, transfers, personal hygiene. Stroke, hemiplegia	arterly Minimum Data Set 3's cognition was intact. R3 assistance of one staff for bed ambulation, toileting, and R3's diagnoses included and hemiparesis affecting his pain, and encephalopathy.			physician promptly of a change in re condition. Therapy and MDS Coordin will also be notified of falls. The MDS Coordinator will update the care plar needed. Completed checklist to be into DON. A mandatory nursing mee will be held on March 10, 2021 to ed nursing staff on new fall policy,	sident nator S n as turned sting		
	fall risk due to havi affecting his right s have staff assist w according to therap were to ensure R3 keep the bed in the fall risk evaluations and as need. Staff appropriately to en	ed 1/27/21, identified R3 was a ing a fall history and stoke side. Interventions include to ith ambulation and transfers by recommendations. Staff wore appropriate footwear, e lowest position, and complete s with each new fall, quarterly, were to use devices sure safety and place blue side of the bed when in bed.			procedure, checklist and training will provided on how to appropriately ass resident who uses a hemi walker for ambulation. The revisions and educa to be completed by 03/15/2021. Qua audits x 3 to ensure the fall procedur are implemented and followed. Audir be completed by DON or designee a brought to facility's quarterly QA mee	sist a ation arterly res ts will and		
	R3's Risk Manager the following: On 12/24/20 at 6:0	ment Reports (RMR) identified 0 p.m., R3 was being assisted eal to the rest room with a gait						

If continuation sheet Page 2 of 12

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/05/2021 APPROVED 0938-0391
STATEMENT OF DE AND PLAN OF COR	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245553	B. WING	i			C 27/2021
NAME OF PROVID	DER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PARKVIEW M/	ANOR NURSING	HOME		-	308 SHERMAN AVENUE ELLSWORTH, MN 56129		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
belt, slipp was his b the t The note inter the 1 R3's the b him pape R3's was the f of ar imple Inter assis assis assis assis assis amb knee had was Inter iden the t	bed and lost his assisted to the puttocks and rig ime of the fall. R3's 12/24/20 f s all lacked evid ventions that w 12/24/20 fall. 8/17/20, progra- bathroom while to the toilet. R3 er dispenser. 8/17/20, Post- being transferr fall. R3's Post-fa hy immediate in emented as a r view on 1/26/2 stant (NA)-B ide stance with tran- pulating. R3 had been lowered to unable to recal view on 1/26/2 tified R3 was fr coilet and had be s due to dizzine asionally when h re of it.	Ind assistance of 1 staff. R3 footing on his right foot and floor by staff. R3 landed on that arm. R3 had no injures at RMR, care plan and progress dence of any immediate ere implemented as a result of ess note identified R3 fell in an unidentified NA transferred hit his head on the toilet fall Evaluation identified R3 ed to the toilet at the time of all Evaluation lacked evidence terventions that were esult of the 12/24/20 fall. 1, at 10:00 a.m. with nursing entified R3 required staff hsfers, toileting, and I right sided weakness, and his buckles when ambulating. He o the floor a few times, but	F	589			

If continuation sheet Page 3 of 12

STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED	
		245553	B. WING		C 01/27/202		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
PARKVI	EW MANOR NURSING	G HOME					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 689	a hemi walker and belt for ambulation hemiplegia on his r ambulate due to the He needed staff to his right arm. Staff on how to ambulate received any trainir walker. Newer staff to ambulate R3. Interview on 1/27/2 physical therapist (R3 had any falls. R after a stroke and h hemi-walker and as belt. The PT expect fell, or had to be low be evaluated to see lowered him to the evaluation and also knew how to use th as hemi-walkers we other equipment. S to use the hemi wa but the restorative s appropriately use th able to train other s appropriately. Interview on 1/27/2 director of nursing when staff lowered been contacted, an retrained on transfe techniques for R3 f no additional interv the falls to prevent	age 3 assistance of 1 staff and a gait and to use the toilet. R3 had ight side, and was tricky to e limited use of his right side. stabilize the right side under received written instructions e residents, but had not ng on how to use the hemi f were not as familiar with how 1, at 2:08 p.m. with the PT) identified he had not heard 3 was admitted to the facility nad improved enough to use a ssistance of 1 staff and a gait ted to be updated if residents wered to the floor so they could e if PT was appropriate. If staff floor, PT would do an o observe staff to ensure they he hemi walker appropriately ere not used as frequently as staff who were trained how to he walker, would have been staff on how to use it 1, at 3:00 p.m., with the (DON) identified R3 had times him to the floor. PT had not ad staff were not observed or erring or ambulating following the falls. There were entions implemented following further falls. R3 had no risk t completed for the fall on	F 6	89			

Facility ID: 00406

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TATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED
		245553	B. WING		01	/27/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
PARKVII	EW MANOR NURSING	G HOME		308 SHERMAN AVENUE ELLSWORTH, MN 56129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 689	8/17/20. Staff were implement interven to complete a fall re- section of the elect be reviewed by the The DON agreed, I should have been et to ensure R3 used provided the prope and transfer safely. The 10/29/20, Fall policy was to protect safety. PT was to be evaluate residents falls, or when a fall resident experience the fall policy. Falls monthly, and during performance impro- management team pharmacist. Reside were to have more interventions imple Therapeutic Diet Pf CFR(s): 483.60(e)(1) §483.60(e)(1) Ther prescribed by the a §483.60(e)(2) The delegate to a regist task of prescribing therapeutic diet, to law.	to follow the policy and tions to prevent falls, and were eport in the Risk Management ronic medical records so it can interdisciplinary team (IDT). R3's falls during transfers evaluated and staff observed the hemi-walker and staff r support for R3 to ambulate Prevention policy identified the ct residents and promote e informed of falls and was to when there were repeated pattern was identified. If a ed a fall, staff were to follow were to be evaluated weekly, g quality assurance and vement meetings with the , medical director and ents identified at a high fall risk in-depth prevention mented. rescribed by Physician 1)(2) eutic Diets apeutic diets must be	F 68			3/15/21

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	СОМ	PLETED	
		245553	B. WING			C 27/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2112021	
	EW MANOR NURSING	G HOME		308 SHERMAN AVENUE ELLSWORTH, MN 56129			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			
F 808	- 1	age 5 tion, interview, and document	F 80	8 Policies will be reviewed and re	vised by		
	review, the facility f meals were served for 1 of 1 resident (soft diet. Findings include: R4's physician orde ordered for a libera diet. R4's diagnose disease. R4's 10/30/20, diet continued to mainta continued to be on natural teeth were continued with che R4's 1/27/21, care chewing problem re required a mechan	Failed to ensure therapeutic according to physician orders (R4) prescribed a mechanical ers dated 1/27/21, identified an lized, regular, mechanical soft es included Parkinson's itian note identified R4 ain a stable weight and a mechanical soft diet. His in poor condition, and he		Interim Dietary Manager and Re Dietician by 3/15/2021. On Marc mandatory dietary staff meeting held. The Registered Dietician w present and education will be pr appropriate measuring devices to adequate portions are being ser according to the menu and also will be provided on how to prepar mechanically soft diet. The inter manager will be attending a serv class on March 9, 2021. Monthly and quarterly x1 will be complete Registered Dietician or designed ensure diet orders are correct at to the MAR and followed by diet Audits will be brought to the faci quarterly QA meeting.	gistered th 10, a will be vill be ovided on to ensure ved education are a im dietary ve-safe v audits x3 ed by e to ccording ary staff.		
	12:15 p.m., C-A sta calibrated utensils appropriate portion received half portio identified she was for green beans ins was indicated by th only person on a m kitchen did not prep foods, staff just cho was able to eat. Sh were trained to pre	and interview on 1/27/21, at ated she was not using for ensuring residents received sizes, adding some residents ons per their request. She also using a four ounce (oz.) scoop stead of a 3 oz. scoop which he dietitian's menu. R4 was the hechanical soft diet. The pare the mechanical soft opped it into a size the resident he was unsure if nursing staff pare mechanically soft foods. e-save trained in the kitchen.					

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		I AND HUMAN SERVICES					FORM	03/05/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ISTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245553	B. WING _					C 27/2021
NAME OF I	PROVIDER OR SUPPLIER			STREE	ADDRESS, CITY, STATE, ZIP COD)E	-	
PARKVI	EW MANOR NURSING	HOME			ERMAN AVENUE VORTH, MN 56129			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
	C-A verified she had one time, but that w working in the facilit The facility's fall and 9/20/20, by the dieti provide ground mea Interview on 1/27/21 dietitian identified st according to the me physician orders. C mechanical soft foo the menu, and nurs trained to prepare in dietitian came to the audits and observe Interview on 1/27/20 administrator verifies safe certified in the manager once appo dietary manager ce A policy was reques provided for dietary Food Procurement, CFR(s): 483.60(i)(1 §483.60(i)(1) - Proc approved or conside state or local author (i) This may include	d been serve-safe certified at vas many years ago before ty. d winter 2020 menu signed on itian identified staff were to at for mechanical soft diets. 1, at 2:18 p.m. with the taff were to serve portion sizes enu, and according to ooks were to prepare the ods according to directions in sing assistants were not nechanical soft diets. The e facility monthly, to perform staff in the kitchen. 0, and 2:45 p.m., with the ed no current staff were serve- kitchen. The new dietary ointed, would receive the ortification once hired. sted, but no policy was staff training. Store/Prepare/Serve-Sanitary)(2) fety requirements.	F 80					3/15/21

Facility ID: 00406

If continuation sheet Page 7 of 12

	(X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DATE SURVEY COMPLETED
CONNECTION	IDENTIFICATION NOWBER.	A. BUILDIN	G	C
	245553	B. WING _		01/27/2021
ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP O	CODE
W MANOR NURSING	G HOME		308 SHERMAN AVENUE ELLSWORTH, MN 56129	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTIO
Continued From pa	age 7	F 81	2	
facilities from using gardens, subject to safe growing and fo	produce grown in facility compliance with applicable pod-handling practices.			
§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.				
by: Based on observa review, the facility f	tion, interview, and document ailed to ensure dietary staff		Policies will be reviewed ar Interim Dietary Manager an Dietician, On March 10 202	d Registered
hand hygiene after surfaces while serv facility failed to ens surfaces were clea equipment to ensure	contact with high touch ing meals. Additionally the ure kitchen equipment and ned regularly, and maintained		dietary meeting will held. The Dietician will provide educat hygiene, serving, prepping a food in accordance with pro- standards for food service s	ne Registered tion on hand and storage of ofessional safely. Menus
Findings include:			menus will also be discusse checklist will be implemente	ed. A cleaning ed and staff
aid (DA)-A of the ki a.m., identified the cracked tiles on the tiles missing, expose mat at the dishwas two tiles were loose basin sink, tan drie bottom of the sink I drying area identifie	tchen on 1/27/21 at 10:08 dishwashing room had four e floor with one and one half sing concrete under the rubber her. At the triple basin sink, e and warped. In the triple d debris was adhered to the basin. Observation of the dish ed a fan was blowing directly		Dietary Manager will be atte serve-safe class on March kitchen will be deep cleaned 3/15/2021. The cracked tile in the dishwashing room wi by 03/12/2021. Monthly aud quarterly x1 will be complet Registered Dietician or des sure solutions are sustained be brought to the quarterly	ending the 9, 2021. The d by s on the floor Il be replaced lits x3 and ed by ignee to make d. Audits will
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa (ii) This provision d facilities from using gardens, subject to safe growing and fo (iii) This provision of from consuming for §483.60(i)(2) - Stor serve food in accor standards for food This REQUIREMED by: Based on observa review, the facility f served food in a sa hand hygiene after surfaces while serve facility failed to ensu- surfaces were clea equipment to ensu- surfaces were clea equipment to ensu- sanitized. Findings include: Continued observa aid (DA)-A of the ki a.m., identified the cracked tiles on the tiles missing, expos- mat at the dishwas two tiles were loose basin sink, tan drie bottom of the sink I drying area identifie towards cups, and	F CORRECTION IDENTIFICATION NUMBER: 245553 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dietary staff served food in a sanitary manner and performed hand hygiene after contact with high touch surfaces while serving meals. Additionally the facility failed to ensure kitchen equipment and surfaces were cleaned regularly, and maintained equipment to ensure the kitchen was properly sanitized.	F CORRECTION IDENTIFICATION NUMBER: A. BUILDIN 245553 B. WING _ PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 7 F 81 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. F 81 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. F This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dietary staff served food in a sanitary manner and performed hand hygiene after contact with high touch surfaces while serving meals. Additionally the facility failed to ensure the kitchen equipment and surfaces while serving meals. Additionally the facility failed to ensure the kitchen was properly sanitized. Findings include: Continued observation and interview with dietary aid (DA)-A of the kitchen on 1/27/21 at 10:08 a.m., identified the dishwashing room had four cracked tiles on the floor with one and one half tiles missing, exposing concrete under the rubber mat at the dishwasher. At the triple basin sink, two tiles were loose and warped. In the triple basin sink, tan dried debris was adhered to the bottom of the sink basin. Observation of the dish drying area identified a fan was blowing directly towards cups, and dishes air drying on racks. The	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245553 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP OF 308 SHERMAN AVENUE ELLSWORTH, MN 56129 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 7 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not proclude residents from consuming foods not procured by the facility. F 812 \$483.60(i)(2) - Store, prepare, distribute and serve food in a accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Policies will be reviewed at Interim Dietary Manager an Dietician. On March 10 202 dietary meeting will held. Th Dietician will provide educas thandards for food service safety. Findings include: Continued observation and interview with dietary ald (DA)-A of the kitchen on 1/27/21 at 10:08 a.m., identified the dishwashing room had four cracked tiles on the floor with one and one half tiles missing, exposing concrete under the rubber mat at the dishwasher. At the triple basin sink, two tiles were loose and warped. In the triple basin sink, tan dried debris was adhered to the bottom of the sink basin. Observation of the dish drying area identified a fan was blowing directly towards cups, and dishes air drying on racks. The

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	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
		245553	A. BUILDIN	G	C 01/27/2021			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	12112021		
PARKVI	EW MANOR NURSING	G HOME		308 SHERMAN AVENUE ELLSWORTH, MN 56129				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETIO DATE		
F 812	the bottom of the d cabinet next to the along the side of the refrigerator identified and upper the grill of the serving islam basin sitting in it. Be containers with dar placed under the P one of the plastic c chunky debris dried refrigerator identified and upper grill of the she had worked at months and the tile started. The maintee tiles were missing. blower on the dishe- identified there was place, but the even cleaning at the end Interview with Cool- a.m., verified the ha microwave door, gr were not thoroughly not had a deep clea- kitchen island sink used routinely, but staff could drain ca was washed daily in unsure who cleanee the sink, and stated quite some time. E	with medium black particles on rip pan. The side of the pan grill had whitish-gray debris le cabinet. Observation of the ed dried debris on the handles of the refrigerator. Observation d identified a sink with a black elow the sink, two plastic k brown dried debris were -trap drain. A strainer was in ontainers and had brown d to it. Observation of the ed dried debris on the handles ne refrigerator. DA-A identified the facility for about two as had been like that since she enance department was aware She was unsure when the es was last cleaned. DA-A also a no cleaning schedule in ing staff was responsible for of the night. (C)-A on 1/27/21, at 10:21 andles on the refrigerator, rill drip pan, and pan cabinet y cleaned. The kitchen had aning in the past year. The had a slow drain and was not the basin was in the sink so nned vegetables. The basin n the dishwasher. She was d the plastic containers under d they have been like that for ach shift was to clean up the e, and the evening shift was to	F 81	2				

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED	
		245553	B. WING		C 01/27/202 ²		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
PARKVIE	EW MANOR NURSING	G HOME		308 SHERMAN AVENUE ELLSWORTH, MN 56129			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		IOULD BE	(X5) COMPLETION DATE	
F 812	dietary manager. S drip pans when the the fan had debris directly towards the unaware that the fa towards the dishes position at the facil had resigned about differences with the that, she had worke tiles had been crac she could rememb the tiles and the sir plan was to fix ther communicate need maintenance depar does not represent old dietary manage and several staff ha manager. She only months, but the kite were not served ac menus because the food required to se many substitutions	age 9 20, when the facility had a new taff would clean the stove and y were able. C-A confirmed in the guard, and was blowing e drying dishes. She was an was not supposed to point . C-A had just resumed a ity during the past month, but t two months ago due to e dietary manager. Prior to ed in the kitchen, and the floor ked and missing for as long as er. Maintenance was aware of nk, she was unsure what the n staff used sticky notes to led repairs in the kitchen to the rtment. C-A stated the kitchen what the staff were like. The er was not able to do the job, ad quit during the time she was worked at the facility for a few chen was in bad shape. Menus cording to the dietitian's e manager would not order the rve the meals. Menus had , and the staff continued to of the concerns of not following	F 81	2			
	cracks, and the sta manager were wor practices. Kitchen s addressed, but the followed. Observation of the at 11:45 a.m., iden during the meal set	chen had fallen through the ff and new interim dietary king towards restoring kitchen sanitation had not yet been menus were now being noon meal service on 1/27/21, tified C-A was wearing gloves rvice. C-A was serving turkey iches, and handled the bread					

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STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION (X) IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245553 (X) IDENTIFICATION NUMBER: 25557777777 (X) IDENTIFICATION NUMBER: 2557777777 (X) IDEN			AND HUMAN SERVICES				FORM	03/05/2021 APPROVED 0938-0391
24553 B. WING 01/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, JP CODE SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS. CITY, STATE, JP CODE OPENDATION STREET ADDRESS. CITY, STATE, JP CODE SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS. CITY, STATE, JP CODE SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS. CITY, STATE, JP CODE SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS. CITY, STATE, JP CODE SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS. CITY, STATE, JP CODE SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS. CITY, STATE, JP CODE STATE STATE ADDRESS STREET ADDRESS. CITY, STATE, JP CODE STATE STATE ADDRESS STREET ADDRESS. CITY, STATE, JP CODE SUMMARY STATEMENT OF DEFICIENCES F 812 F 812 F 812 </td <td>STATEMENT</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>l` í</td> <td></td> <td>E CONSTRUCTION</td> <td>(X3) DATE COM</td> <td>E SURVEY PLETED</td>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
PARKVIEW MANOR NURSING HOME 308 SHERMAN AVENUE ELLSWORTH, MN 68129 PHEFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR ISC DERTIFYING INFORMATION) ID PREFIX FAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR ISC DERTIFYING INFORMATION) ID PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OWNETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR ISC DERTIFYING INFORMATION) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY F 812 Continued From page 10 refrigerator, opened the refrigerator to get condiments, and without removing her gloves and washing her hands, she continued to serve bread with her gloved hands, and served up food trays. F 812 F 812 Interview on 12/27/21, at 12:25 p.m., with C-A dend thand hygiene performed after contact with high touch surfaces and before direct contact with food served to residents. F 812 Interview on 12/27/21, at 12:47 p.m., with C-B identified prior to the old dietary manager leaving, the menus were not being followed according to the menus. The old dietary manager relaxing the menus were not being followed according to the normal procedure prior to her taking the dietary manager role. Staff offered to assist her with orders until she was familiar with the process, but the dietary manager relaxed help. Staff were also not scheduled correctly during the time between October 2020, and mid January 2021. The schedule would often not have a cook or dietary ald scheduled, and staff would have to call to fill the o			245553	B. WING	i			
PARKVIEW MANOR NURSING HOME ELLSWORTH, MN 56129 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S HAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENDE COMMENDE TAG ID PROVIDER'S HAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENDE COMMENDE TAG COMMENDE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENDE CROSS-REFERENCED TO THE APPR	NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
Pričej X TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PRĚTX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPÉTIO INFERIOR F 812 Continued From page 10 refrigerator, opened the refrigerator to get condiments, and without removing her gloves and washing her hands, she continued to serve bread with her gloved hands, and served up food trays. F 812 F 812 Interview on 12/27/21, at 12:25 p.m., with C-A verified she had not removed her gloves and performed hand hygiene after touching the door handles of the refrigerator. The handle had not been wiped down following observation of debris on them. C-A agreed gloves should be removed and hand hygiene performed after contact with high touch surfaces and before direct contact with high touch surfaces and before direct contact with high cocording to the end being followed according to the menus. The old dietary manager leaving, the menus were not being followed according to the mormal procedure prior to her taking the dietary manager to be the taking the dietary manager out schedule dorrectly during the time between October 2020, and mid January 2021. The schedule would often not have a cook or dietary aid staff would have to call to fill the open shifts. Many staff resigned, leaving the kitchen under staffed. Lite of the schedule and staff would have to call to fill the open shifts. Many staff resigned, leaving the kitchen under staffed.	PARKVIE	W MANOR NURSING	ЭНОМЕ					
refrigerator, opened the refrigerator to get condiments, and without removing her gloves and washing her hands, she continued to serve bread with her gloved hands, and served up food trays. Interview on 12/27/21, at 12:25 p.m., with C-A verified she had not removed her gloves and performed hand hygiene after touching the door handles of the refrigerator. The handle had not been wiped down following observation of debris on them. C-A agreed gloves should be removed and hand hygiene performed after contact with high touch surfaces and before direct contact with food served to residents. Interview on 12/27/21, at 12:47 p.m., with C-B identified prior to the old dietary manager leaving, the menus were not being followed according to the menus. The old dietary manager was not ordering food according to the menu and frequently ordered the incorrect food. She had not ordered the food a week in advance as had been the normal procedure prior to he taking the dietary manager refused help. Staff were also not scheduled correctly during the time between October 2020, and mid January 2021. The scheduled correctly during the time between October 2020, and mid January 2021. The scheduled correctly during the time between October 2020, at staff worel also the as the leaving the kitchen under staffed. Interview on 12/27/20, at 2:18 p.m., with the dietitian identified the facility had issues with	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
sanitation for a long time. The kitchen staff should have been trained in kitchen sanitation upon hire, and a cleaning list was expected to be in place. At one time there was a cleaning schedule for the	F 812	refrigerator, opened condiments, and wi washing her hands, with her gloved han Interview on 12/27/2 verified she had no performed hand hy handles of the refrig been wiped down fo on them. C-A agree and hand hygiene p high touch surfaces food served to resid Interview on 12/27/2 identified prior to th the menus were no the menus. The old ordering food accor frequently ordered the ordered the food a the normal procedu dietary manager rol with orders until she process, but the die Staff were also not time between Octol 2021. The schedule or dietary aid scheo call to fill the open s leaving the kitchen Interview on 12/27/2 dietitian identified th sanitation for a long have been trained i and a cleaning list w	d the refrigerator to get ithout removing her gloves and , she continued to serve bread hds, and served up food trays. 21, at 12:25 p.m., with C-A t removed her gloves and giene after touching the door gerator. The handle had not ollowing observation of debris ed gloves should be removed berformed after contact with s and before direct contact with dents. 21, at 12:47 p.m., with C-B e old dietary manager leaving, t being followed according to I dietary manager was not rding to the menu and the incorrect food. She had not week in advance as had been are prior to her taking the le. Staff offered to assist her e was familiar with the etary manager refused help. scheduled correctly during the ber 2020, and mid January e would often not have a cook duled, and staff would have to shifts. Many staff resigned, under staffed. 20, at 2:18 p.m., with the ne facility had issues with g time. The kitchen staff should n kitchen sanitation upon hire, was expected to be in place. At	F	312	DEFICIENCY)		

Facility ID: 00406

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		HAND HUMAN SERVICES				FORM	03/05/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245553	B. WING _				C 27/2021
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PARKVI	EW MANOR NURSING	3 HOME			8 SHERMAN AVENUE LLSWORTH, MN 56129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	kitchen staff, howey manager deleted m vacating the positio with the previous di follow-through, and the right person for confirmed the menu and staff alerted the substitutions being the first issue corre left. Staff were to re hand hygiene any ti high tough surfaces Kitchen equipment schedule and betwe kitchen was also to schedule to preven dietitian also agree serving island sink removed and any c maintain a sanitary department had ma needed updating. A kitchen sanitation not provided. The 3/4/20, Handw policy identified stat donning gloves, and use was not a repla	ver one of the former dietary nany documents prior to on. There were also concerns ietary manager regarding I that person was simply not the job. The dietitian us were not being followed, e dietitian of the many made. Following menus was beted after the dietary manger emove gloves and perform ime they made contact with s and before serving food. was to be cleaned on a een meal services. The o have a deep cleaning t food-borne illnesses. The d equipment such as the should be in working order or cracked tiles replaced to environment. The dietary any outdated policies that the policy was requested, and rashing and Hand Hygiene ff were to wash hands before d after removing gloves. Glove acement for performing hand was provided for hand hygiene	F 81	112			

Facility ID: 00406

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