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.

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by 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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

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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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00406	A. BUILDING: _____ B. WING _____	C 01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/25/21 through 1/27/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be substantiated: H5553009C (MN00069212) with licensing orders issued. H5553010C (MN00065168) with licensing orders issued. The following complaint was found to be unsubstantiated: H5553011C (MN00065637) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

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2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure interventions were assessed and implemented to prevent falls and staff were trained on medical equipment used for safe ambulation for 1 of 3 residents (R3).	2 830	corrected	3/15/21

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2 830	Continued From page 3 Findings include: R3's 12/30/20, quarterly Minimum Data Set (MDS) identified R3's cognition was intact. R3 required extensive assistance of one staff for bed mobility, transfers, ambulation, toileting, and personal hygiene. R3's diagnoses included Stroke, hemiplegia and hemiparesis affecting his right side, chronic pain, and encephalopathy. R3's care plan dated 1/27/21, identified R3 was a fall risk due to having a fall history and stoke affecting his right side. Interventions include to have staff assist with ambulation and transfers according to therapy recommendations. Staff were to ensure R3 wore appropriate footwear, keep the bed in the lowest position, and complete fall risk evaluations with each new fall, quarterly, and as need. Staff were to use devices appropriately to ensure safety and place blue mats beside each side of the bed when in bed. R3's Risk Management Reports (RMR) identified the following: On 12/24/20 at 6:00 p.m., R3 was being assisted after the supper meal to the rest room with a gait belt, hemi-walker, and assistance of 1 staff. R3 slipped and lost his footing on his right foot and was assisted to the floor by staff. R3 landed on his buttocks and right arm. R3 had no injures at the time of the fall. The R3's 12/24/20 RMR, care plan and progress notes all lacked evidence of any immediate interventions that were implemented as a result of the 12/24/20 fall. R3's 8/17/20, progress note identified R3 fell in the bathroom while an unidentified NA transferred	2 830		

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2 830	Continued From page 4	2 830		

him to the toilet. R3 hit his head on the toilet paper dispenser.

R3's 8/17/20, Post-fall Evaluation identified R3 was being transferred to the toilet at the time of the fall. R3's Post-fall Evaluation lacked evidence of any immediate interventions that were implemented as a result of the 12/24/20 fall.

Interview on 1/26/21, at 10:00 a.m. with nursing assistant (NA)-B identified R3 required staff assistance with transfers, toileting, and ambulating. R3 had right sided weakness, and his knee occasionally buckles when ambulating. He had been lowered to the floor a few times, but was unable to recall when.

Interview on 1/26/21, at 10:03 a.m. with (NA)-B identified R3 was frequently dizzy when getting off the toilet and had been lowered to the floor many times due to dizziness. Also R3's knee buckles occasionally when he walks, and staff need to be aware of it.

Interview on 1/26/21, at 2:42 p.m., with registered nurse (RN)-A identified R3 had a stroke and used a hemi walker and assistance of 1 staff and a gait belt for ambulation and to use the toilet. R3 had hemiplegia on his right side, and was tricky to ambulate due to the limited use of his right side. He needed staff to stabilize the right side under his right arm. Staff received written instructions on how to ambulate residents, but had not received any training on how to use the hemi walker. Newer staff were not as familiar with how to ambulate R3.

Interview on 1/27/21, at 2:08 p.m. with the physical therapist (PT) identified he had not heard R3 had any falls. R3 was admitted to the facility

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2 830	Continued From page 5	2 830		

after a stroke and had improved enough to use a hemi-walker and assistance of 1 staff and a gait belt. The PT expected to be updated if residents fell, or had to be lowered to the floor so they could be evaluated to see if PT was appropriate. If staff lowered him to the floor, PT would do an evaluation and also observe staff to ensure they knew how to use the hemi walker appropriately as hemi-walkers were not used as frequently as other equipment. Staff were not educated on how to use the hemi walker when he was admitted, but the restorative staff who were trained how to appropriately use the walker, would have been able to train other staff on how to use it appropriately.

Interview on 1/27/21, at 3:00 p.m., with the director of nursing (DON) identified R3 had times when staff lowered him to the floor. PT had not been contacted, and staff were not observed or retrained on transferring or ambulating techniques for R3 following the falls. There were no additional interventions implemented following the falls to prevent further falls. R3 had no risk management report completed for the fall on 8/17/20. Staff were to follow the policy and implement interventions to prevent falls, and were to complete a fall report in the Risk Management section of the electronic medical records so it can be reviewed by the interdisciplinary team (IDT). The DON agreed, R3's falls during transfers should have been evaluated and staff observed to ensure R3 used the hemi-walker and staff provided the proper support for R3 to ambulate and transfer safely.

The 10/29/20, Fall Prevention policy identified the policy was to protect residents and promote safety. PT was to be informed of falls and was to evaluate residents when there were repeated

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2 830	Continued From page 6 falls, or when a fall pattern was identified. If a resident experienced a fall, staff were to follow the fall policy. Falls were to be evaluated weekly, monthly, and during quality assurance and performance improvement meetings with the management team, medical director and pharmacist. Residents identified at a high fall risk were to have more in-depth prevention interventions implemented. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed.	21000		3/15/21

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21000	Continued From page 7 This MN 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. 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 fan had debris adhered to the guard. Observation of the microwave identified dried drippings on the bottom of the microwave door. Observation of the stove identified the drip pan under the grill had thick white debris with medium black particles on the bottom of the drip pan. The side of the pan cabinet next to the grill had whitish-gray debris along the side of the cabinet. Observation of the refrigerator identified dried debris on the handles and upper the grill of the refrigerator. Observation of the serving island identified a sink with a black basin sitting in it. Below the sink, two plastic containers with dark brown dried debris were	21000	Corrected	

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21000	Continued From page 8	21000		

placed under the P-trap drain. A strainer was in one of the plastic containers and had brown chunky debris dried to it. Observation of the refrigerator identified dried debris on the handles and upper grill of the refrigerator. DA-A identified she had worked at the facility for about two months and the tiles had been like that since she started. The maintenance department was aware tiles were missing. She was unsure when the blower on the dishes was last cleaned. DA-A also identified there was no cleaning schedule in place, but the evening staff was responsible for cleaning at the end of the night.

Interview with Cook (C)-A on 1/27/21, at 10:21 a.m., verified the handles on the refrigerator, microwave door, grill drip pan, and pan cabinet were not thoroughly cleaned. The kitchen had not had a deep cleaning in the past year. The kitchen island sink had a slow drain and was not used routinely, but the basin was in the sink so staff could drain canned vegetables. The basin was washed daily in the dishwasher. She was unsure who cleaned the plastic containers under the sink, and stated they have been like that for quite some time. Each shift was to clean up the kitchen, while in use, and the evening shift was to clean all the handles and high touch areas at the end of the night. No cleaning schedule were presently in place, and had not been place since at least October 2020, when the facility had a new dietary manager. Staff would clean the stove and drip pans when they were able. C-A confirmed the fan had debris in the guard, and was blowing directly towards the drying dishes. She was unaware that the fan was not supposed to point towards the dishes. C-A had just resumed a position at the facility during the past month, but had resigned about two months ago due to differences with the dietary manager. Prior to

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that, she had worked in the kitchen, and the floor tiles had been cracked and missing for as long as she could remember. Maintenance was aware of the tiles and the sink, she was unsure what the plan was to fix them staff used sticky notes to communicate needed repairs in the kitchen to the maintenance department. C-A stated the kitchen does not represent what the staff were like. The old dietary manager was not able to do the job, and several staff had quit during the time she was manager. She only worked at the facility for a few months, but the kitchen was in bad shape. Menus were not served according to the dietitian's menus because the manager would not order the food required to serve the meals. Menus had many substitutions, and the staff continued to notify the dietitian of the concerns of not following the menus. The kitchen had fallen through the cracks, and the staff and new interim dietary manager were working towards restoring kitchen practices. Kitchen sanitation had not yet been addressed, but the menus were now being followed.

Observation of the noon meal service on 1/27/21, at 11:45 a.m., identified C-A was wearing gloves during the meal service. C-A was serving turkey commercial sandwiches, and handled the bread with her gloved hands. C-A walked to the 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

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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 her taking the dietary manager role. Staff offered to assist her with orders until she was familiar with the process, but the dietary manager refused 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 aid scheduled, and staff would have to call to fill the open shifts. Many staff resigned, leaving the kitchen under staffed.

Interview on 12/27/20, at 2:18 p.m., with the dietitian identified the facility had issues with 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 kitchen staff, however one of the former dietary manager deleted many documents prior to vacating the position. There were also concerns with the previous dietary manager regarding follow-through, and that person was simply not the right person for the job. The dietitian confirmed the menus were not being followed, and staff alerted the dietitian of the many substitutions being made. Following menus was the first issue corrected after the dietary manger left. Staff were to remove gloves and perform hand hygiene any time they made contact with

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21000	Continued From page 11 high tough surfaces and before serving food. Kitchen equipment was to be cleaned on a schedule and between meal services. The kitchen was also to have a deep cleaning schedule to prevent food-borne illnesses. The dietitian also agreed equipment such as the serving island sink should be in working order or removed and any cracked tiles replaced to maintain a sanitary environment. The dietary department had many outdated policies that needed updating. A kitchen sanitation policy was requested, and not provided. The 3/4/20, Handwashing and Hand Hygiene policy identified staff were to wash hands before donning gloves, and after removing gloves. Glove use was not a replacement for performing hand hygiene. No policy was provided for hand hygiene specific for kitchen staff. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to sanitation, food preparation and kitchen sanitation. The administrator, director of nursing, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance The facility could report those findings to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		

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F 000	INITIAL COMMENTS From 1/25/21 through 1/27/21, an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5553009C (MN00069212) with deficiencies cited at F808 and F812 H5553010C (MN00065168) with deficiencies cited at F689 The following complaint was found to be unsubstantiated: H5553011C (MN00065637) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		3/15/21

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

Electronically Signed | 02/25/2021

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F 689	Continued From page 1 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 and document review, the facility failed to ensure interventions were assessed and implemented to prevent falls and staff were trained on medical equipment used for safe ambulation for 1 of 3 residents (R3). Findings include: R3's 12/30/20, quarterly Minimum Data Set (MDS) identified R3's cognition was intact. R3 required extensive assistance of one staff for bed mobility, transfers, ambulation, toileting, and personal hygiene. R3's diagnoses included Stroke, hemiplegia and hemiparesis affecting his right side, chronic pain, and encephalopathy. R3's care plan dated 1/27/21, identified R3 was a fall risk due to having a fall history and stoke affecting his right side. Interventions include to have staff assist with ambulation and transfers according to therapy recommendations. Staff were to ensure R3 wore appropriate footwear, keep the bed in the lowest position, and complete fall risk evaluations with each new fall, quarterly, and as need. Staff were to use devices appropriately to ensure safety and place blue mats beside each side of the bed when in bed. R3's Risk Management Reports (RMR) identified the following: On 12/24/20 at 6:00 p.m., R3 was being assisted after the supper meal to the rest room with a gait	F 689	Fall policy to be reviewed and revised by DON. A checklist will be developed for the charge nurses with step by step instructions on procedures to follow when a fall occurs. The checklist will include the proper assessments, immediate interventions implemented to ensure resident's safety and to notify family and physician promptly of a change in resident condition. Therapy and MDS Coordinator will also be notified of falls. The MDS Coordinator will update the care plan as needed. Completed checklist to be turned into DON. A mandatory nursing meeting will be held on March 10, 2021 to educate nursing staff on new fall policy, procedure, checklist and training will be provided on how to appropriately assist a resident who uses a hemi walker for ambulation. The revisions and education to be completed by 03/15/2021. Quarterly audits x 3 to ensure the fall procedures are implemented and followed. Audits will be completed by DON or designee and brought to facility's quarterly QA meeting.	

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belt, hemi-walker, and assistance of 1 staff. R3 slipped and lost his footing on his right foot and was assisted to the floor by staff. R3 landed on his buttocks and right arm. R3 had no injures at the time of the fall.

The R3's 12/24/20 RMR, care plan and progress notes all lacked evidence of any immediate interventions that were implemented as a result of the 12/24/20 fall.

R3's 8/17/20, progress note identified R3 fell in the bathroom while an unidentified NA transferred him to the toilet. R3 hit his head on the toilet paper dispenser.

R3's 8/17/20, Post-fall Evaluation identified R3 was being transferred to the toilet at the time of the fall. R3's Post-fall Evaluation lacked evidence of any immediate interventions that were implemented as a result of the 12/24/20 fall.

Interview on 1/26/21, at 10:00 a.m. with nursing assistant (NA)-B identified R3 required staff assistance with transfers, toileting, and ambulating. R3 had right sided weakness, and his knee occasionally buckles when ambulating. He had been lowered to the floor a few times, but was unable to recall when.

Interview on 1/26/21, at 10:03 a.m. with (NA)-B identified R3 was frequently dizzy when getting off the toilet and had been lowered to the floor many times due to dizziness. Also R3's knee buckles occasionally when he walks, and staff need to be aware of it.

Interview on 1/26/21, at 2:42 p.m., with registered nurse (RN)-A identified R3 had a stroke and used

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a hemi walker and assistance of 1 staff and a gait belt for ambulation and to use the toilet. R3 had hemiplegia on his right side, and was tricky to ambulate due to the limited use of his right side. He needed staff to stabilize the right side under his right arm. Staff received written instructions on how to ambulate residents, but had not received any training on how to use the hemi walker. Newer staff were not as familiar with how to ambulate R3.

Interview on 1/27/21, at 2:08 p.m. with the physical therapist (PT) identified he had not heard R3 had any falls. R3 was admitted to the facility after a stroke and had improved enough to use a hemi-walker and assistance of 1 staff and a gait belt. The PT expected to be updated if residents fell, or had to be lowered to the floor so they could be evaluated to see if PT was appropriate. If staff lowered him to the floor, PT would do an evaluation and also observe staff to ensure they knew how to use the hemi walker appropriately as hemi-walkers were not used as frequently as other equipment. Staff were not educated on how to use the hemi walker when he was admitted, but the restorative staff who were trained how to appropriately use the walker, would have been able to train other staff on how to use it appropriately.

Interview on 1/27/21, at 3:00 p.m., with the director of nursing (DON) identified R3 had times when staff lowered him to the floor. PT had not been contacted, and staff were not observed or retrained on transferring or ambulating techniques for R3 following the falls. There were no additional interventions implemented following the falls to prevent further falls. R3 had no risk management report completed for the fall on

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F 689	Continued From page 4 8/17/20. Staff were to follow the policy and implement interventions to prevent falls, and were to complete a fall report in the Risk Management section of the electronic medical records so it can be reviewed by the interdisciplinary team (IDT). The DON agreed, R3's falls during transfers should have been evaluated and staff observed to ensure R3 used the hemi-walker and staff provided the proper support for R3 to ambulate and transfer safely. The 10/29/20, Fall Prevention policy identified the policy was to protect residents and promote safety. PT was to be informed of falls and was to evaluate residents when there were repeated falls, or when a fall pattern was identified. If a resident experienced a fall, staff were to follow the fall policy. Falls were to be evaluated weekly, monthly, and during quality assurance and performance improvement meetings with the management team, medical director and pharmacist. Residents identified at a high fall risk were to have more in-depth prevention interventions implemented.	F 689		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by:	F 808		3/15/21

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F 808	Continued From page 5 Based on observation, interview, and document review, the facility failed to ensure therapeutic meals were served according to physician orders for 1 of 1 resident (R4) prescribed a mechanical soft diet. Findings include: R4's physician orders dated 1/27/21, identified an ordered for a liberalized, regular, mechanical soft diet. R4's diagnoses included Parkinson's disease. R4's 10/30/20, dietitian note identified R4 continued to maintain a stable weight and continued to be on a mechanical soft diet. His natural teeth were in poor condition, and he continued with chewing difficulty. R4's 1/27/21, care plan identified R4 had a chewing problem related to poor oral status and required a mechanical soft diet, and assistance of one staff for meals. R4 was to eat in the dining room. During observation and interview on 1/27/21, at 12:15 p.m., C-A stated she was not using calibrated utensils for ensuring residents received appropriate portion sizes, adding some residents received half portions per their request. She also identified she was using a four ounce (oz.) scoop for green beans instead of a 3 oz. scoop which was indicated by the dietitian's menu. R4 was the only person on a mechanical soft diet. The kitchen did not prepare the mechanical soft foods, staff just chopped it into a size the resident was able to eat. She was unsure if nursing staff were trained to prepare mechanically soft foods. Staff were not serve-save trained in the kitchen.	F 808	Policies will be reviewed and revised by Interim Dietary Manager and Registered Dietician by 3/15/2021. On March 10, a mandatory dietary staff meeting will be held. The Registered Dietician will be present and education will be provided on appropriate measuring devices to ensure adequate portions are being served according to the menu and also education will be provided on how to prepare a mechanically soft diet. The interim dietary manager will be attending a serve-safe class on March 9, 2021. Monthly audits x3 and quarterly x1 will be completed by Registered Dietician or designee to ensure diet orders are correct according to the MAR and followed by dietary staff. Audits will be brought to the facility's quarterly QA meeting.	

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F 808	Continued From page 6 C-A verified she had been serve-safe certified at one time, but that was many years ago before working in the facility. The facility's fall and winter 2020 menu signed on 9/20/20, by the dietitian identified staff were to provide ground meat for mechanical soft diets. Interview on 1/27/21, at 2:18 p.m. with the dietitian identified staff were to serve portion sizes according to the menu, and according to physician orders. Cooks were to prepare the mechanical soft foods according to directions in the menu, and nursing assistants were not trained to prepare mechanical soft diets. The dietitian came to the facility monthly, to perform audits and observe staff in the kitchen. Interview on 1/27/20, and 2:45 p.m., with the administrator verified no current staff were serve-safe certified in the kitchen. The new dietary manager once appointed, would receive the dietary manager certification once hired. A policy was requested, but no policy was provided for dietary staff training.	F 808		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		3/15/21

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F 812	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. 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 fan had debris adhered to the guard. Observation of the microwave identified dried drippings on the bottom of the microwave door. Observation of the stove identified the drip pan under the grill had	F 812	Policies will be reviewed and revised by Interim Dietary Manager and Registered Dietician. On March 10 2021, a mandatory dietary meeting will held. The Registered Dietician will provide education on hand hygiene, serving, prepping and storage of food in accordance with professional standards for food service safely. Menus and the importance of following the menus will also be discussed. A cleaning checklist will be implemented and staff educated on cleaning measures. Interim Dietary Manager will be attending the serve-safe class on March 9, 2021. The kitchen will be deep cleaned by 3/15/2021. The cracked tiles on the floor in the dishwashing room will be replaced by 03/12/2021. Monthly audits x3 and quarterly x1 will be completed by Registered Dietician or designee to make sure solutions are sustained. Audits will be brought to the quarterly QA meeting.	

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thick white debris with medium black particles on the bottom of the drip pan. The side of the pan cabinet next to the grill had whitish-gray debris along the side of the cabinet. Observation of the refrigerator identified dried debris on the handles and upper the grill of the refrigerator. Observation of the serving island identified a sink with a black basin sitting in it. Below the sink, two plastic containers with dark brown dried debris were placed under the P-trap drain. A strainer was in one of the plastic containers and had brown chunky debris dried to it. Observation of the refrigerator identified dried debris on the handles and upper grill of the refrigerator. DA-A identified she had worked at the facility for about two months and the tiles had been like that since she started. The maintenance department was aware tiles were missing. She was unsure when the blower on the dishes was last cleaned. DA-A also identified there was no cleaning schedule in place, but the evening staff was responsible for cleaning at the end of the night.

Interview with Cook (C)-A on 1/27/21, at 10:21 a.m., verified the handles on the refrigerator, microwave door, grill drip pan, and pan cabinet were not thoroughly cleaned. The kitchen had not had a deep cleaning in the past year. The kitchen island sink had a slow drain and was not used routinely, but the basin was in the sink so staff could drain canned vegetables. The basin was washed daily in the dishwasher. She was unsure who cleaned the plastic containers under the sink, and stated they have been like that for quite some time. Each shift was to clean up the kitchen, while in use, and the evening shift was to clean all the handles and high touch areas at the end of the night. No cleaning schedule were presently in place, and had not been place since

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	245553	A. BUILDING _____ B. WING _____	C 01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	**308 SHERMAN AVENUE ELLSWORTH, MN 56129**

(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
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at least October 2020, when the facility had a new dietary manager. Staff would clean the stove and drip pans when they were able. C-A confirmed the fan had debris in the guard, and was blowing directly towards the drying dishes. She was unaware that the fan was not supposed to point towards the dishes. C-A had just resumed a position at the facility during the past month, but had resigned about two months ago due to differences with the dietary manager. Prior to that, she had worked in the kitchen, and the floor tiles had been cracked and missing for as long as she could remember. Maintenance was aware of the tiles and the sink, she was unsure what the plan was to fix them staff used sticky notes to communicate needed repairs in the kitchen to the maintenance department. C-A stated the kitchen does not represent what the staff were like. The old dietary manager was not able to do the job, and several staff had quit during the time she was manager. She only worked at the facility for a few months, but the kitchen was in bad shape. Menus were not served according to the dietitian's menus because the manager would not order the food required to serve the meals. Menus had many substitutions, and the staff continued to notify the dietitian of the concerns of not following the menus. The kitchen had fallen through the cracks, and the staff and new interim dietary manager were working towards restoring kitchen practices. Kitchen sanitation had not yet been addressed, but the menus were now being followed.

Observation of the noon meal service on 1/27/21, at 11:45 a.m., identified C-A was wearing gloves during the meal service. C-A was serving turkey commercial sandwiches, and handled the bread with her gloved hands. C-A walked to the

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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 her taking the dietary manager role. Staff offered to assist her with orders until she was familiar with the process, but the dietary manager refused 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 aid scheduled, and staff would have to call to fill the open shifts. Many staff resigned, leaving the kitchen under staffed.

Interview on 12/27/20, at 2:18 p.m., with the dietitian identified the facility had issues with 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

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kitchen staff, however one of the former dietary manager deleted many documents prior to vacating the position. There were also concerns with the previous dietary manager regarding follow-through, and that person was simply not the right person for the job. The dietitian confirmed the menus were not being followed, and staff alerted the dietitian of the many substitutions being made. Following menus was the first issue corrected after the dietary manger left. Staff were to remove gloves and perform hand hygiene any time they made contact with high tough surfaces and before serving food. Kitchen equipment was to be cleaned on a schedule and between meal services. The kitchen was also to have a deep cleaning schedule to prevent food-borne illnesses. The dietitian also agreed equipment such as the serving island sink should be in working order or removed and any cracked tiles replaced to maintain a sanitary environment. The dietary department had many outdated policies that needed updating.

A kitchen sanitation policy was requested, and not provided.

The 3/4/20, Handwashing and Hand Hygiene policy identified staff were to wash hands before donning gloves, and after removing gloves. Glove use was not a replacement for performing hand hygiene. No policy was provided for hand hygiene specific for kitchen staff.