

Protecting, Maintaining and Improving the Health of All Minnes ot ans

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: 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

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,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



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,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	.E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		00406	B. WING		01/2	; 7/2021		
NAME OF	PROVIDER OR SUPPLIER			STATE ZIP CODE	1 01/2	1/2021		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PARKVIEW MANOR NURSING HOME 308 SHERMAN AVENUE							
PARKVII	EW MANOR NURSING	ELLSWO	RTH, MN 56	129				
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2 000	Initial Comments		2 000					
	****ATTE	NTION*****						
	NH LICENSING	CORRECTION ORDER						
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment 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.							
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.						
	survey was conduct with State Licensure NOT in compliance Please indicate in y correction that you	rs: 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.						

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/25/21 **Electronically Signed**

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ED: ` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED	
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	substantiated: H5553009C (MN00 issued. H5553010C (MN00 issued. The following compunsubstantiated: H5553011C (MN00 Minnesota Department of Hearyou electronically, is necessary for Staenter the avour in the state of the avour in the state of the avour in the state of the state o	nent of Health is docume. Correction Orders using ag numbers have been sota state statutes/rules are assigned tag number eft column entitled "ID Fatute/rule out of compliancy Statement of Deficites the "To Comply" porter. This column also includes in violation of the statement, "This Rule is not ollowing the surveyors find the defendent of Correction are rection. To participate in the elections are orders consistent artment of Health can 14-01, available at tate.mn.us/divs/fpc/proferications are considered artment of defendent are elections.	enting g for Prefix nce is encies" ion of udes ate ot met ndings nd ronic t with linfo/inf ted to rection se				

Minnesota Department of Health

STATE FORM 3TCX11 If continuation sheet 2 of 12

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
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	heading completion be corrected prior to the Minnesota Depa is enrolled in ePOC	nsure process, under the date, the date your orders will be electronically submitting to artment of Health. The facility and therefore a signature is pottom of the first page of				
	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.					
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			3/15/21
	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.					
	by: Based on interview facility failed to ensi assessed and imple staff were trained o	and document review, the ure interventions were emented to prevent falls and n medical equipment used for 1 of 3 residents (R3).		corrected		

Minnesota Department of Health

STATE FORM 3TCX11 If continuation sheet 3 of 12

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PARKVII	EW MANOR NURSING	HOME		RMAN AVENI RTH, MN 56				
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2 830	Continued From pa	ige 3		2 830				
	Findings include: R3's 12/30/20, qua (MDS) identified R3 required extensive mobility, transfers, personal hygiene. If Stroke, hemiplegia right side, chronic pure R3's care plan date fall risk due to having affecting his right shave staff assist with according to the rap were to ensure R3 keep the bed in the fall risk evaluations and as need. Staff appropriately to ensure the following: R3's Risk Manager 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 his buttocks and righte time of the fall. The R3's 12/24/20 notes all lacked eviinterventions that we the 12/24/20 fall.	B's cognition vassistance of ambulation, to R3's diagnose and hemipardoain, and encoded 1/27/21, ideng a fall historide. Intervention were appropriately recommend wore appropriately recommend were to use of sure safety ariside of the bear ment Reports of p.m., R3 was all to the rest and assistance footing on his floor by staff that arm. R3 his RMR, care pleance of any	was intact. R3 f one staff for bed oileting, and es included esis affecting his ephalopathy. entified R3 was a ry and stoke ions include to n and transfers dations. Staff riate footwear, ion, and complete ew fall, quarterly, devices nd place blue d when in bed. (RMR) identified as being assisted as include to as a being assisted as being assisted as being assisted as being assisted as a being assisted as being assisted and in and progress immediate					
	R3's 8/17/20, progr the bathroom while							

Minnesota Department of Health

STATE FORM 3TCX11 If continuation sheet 4 of 12

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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PARKVII	EW MANOR NURSING	HOME	MAN AVEN			
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2 830	Continued From pa	ge 4	2 830			
	him to the toilet. R3 paper dispenser.	hit his head on the toilet				
	was being transferr the fall. R3's Post-for of any immediate in	fall Evaluation identified R3 red to the toilet at the time of all Evaluation lacked evidence atterventions that were 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.					
	nurse (RN)-A idential hemi walker and belt for ambulation hemiplegia on his rambulate due to the He needed staff to his right arm. Staff on how to ambulate received any training	1, at 2:42 p.m., with registered ified R3 had a stroke and used 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 ag on how to use the hemi is were not as familiar with how				
	physical therapist (I	1, at 2:08 p.m. with the PT) identified he had not heard 3 was admitted to the facility				

Minnesota Department of Health

STATE FORM STATE FORM 3TCX11 If continuation sheet 5 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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2 830	Continued From pa	ge 5		2 830				
	after a stroke and 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. So to use the hemi wal but the restorative sappropriately use the able to train other sappropriately.	ssistance of 1 ted to be upd wered to the f e if PT was ap floor, PT wou observe state hemi walke ere not used a taff were not lker when he staff who were ne walker, wo	staff and a gait lated if residents floor so they could opropriate. If staff ald do an ff to ensure they er appropriately as frequently as educated on how was admitted, the trained how to build have been					
	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.							
	policy was to protect safety. PT was to be evaluate residents	ct residents a e informed of	nd promote f falls and was to					

Minnesota Department of Health

STATE FORM 6899 3TCX11 If continuation sheet 6 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ъ.				SURVEY PLETED	
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2 830	Continued From page 6			2 830			
	resident experience the fall policy. Falls monthly, and during performance impro- management team, pharmacist. Reside	pattern was identified. If ed a fall, staff were to foll were to be evaluated we gap quality assurance and vement meetings with the medical director and ents identified at a high fain-depth prevention mented.	low eekly, ne				
	The director of nurs review/revise policie falls, accidents and proper assessment implemented and the of a change in concestaff on the policies for evaluating and rimplementation of the developed, with the	HOD OF CORRECTION in the sign of designee, could see and procedures related resident supervision to a and interventions are been provider is promptly not and procedures. A system on itoring consistent these policies could be a results of these audits by a Quality Assurance sew.	ed to assure eing otified cate tem				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twent	ty-one				
21000	MN Rule 4658.0610 Requirements-Hygi	O Subp. 4 Dietary Staff ene.		21000			3/15/21
	wash their hands and their arms with soal washing facility before as often as is necessafter smoking, eating handling soiled equivalent.	Dietary staff must thorond the exposed portions p and warm water in a hore starting work, during sary to keep them clearing, drinking, using the to ipment or utensils. Dietair fingernails clean and	of and g work n, and ilet, or				

Minnesota Department of Health

STATE FORM 3TCX11 If continuation sheet 7 of 12

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S	SUPPLIER/CLIA TION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
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	00406			B. WING		01/2	; 7/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PARKVII	EW MANOR NURSING	HOME		RMAN AVEN			
			ELLSWO	RTH, MN 56	129		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21000	Continued From pa	ige 7		21000			
21000	This MN Requiremby: Based on observative review, the facility fiserved food in a sath and hygiene after surfaces while service facility failed to ensurfaces were cleatequipment to ensurfaces were cleatequipment to ensurfaces were cleatequipment to ensurfaces. Findings include: Continued observationaries and (DA)-A of the kital a.m., identified the cracked tiles on the tiles missing, exposimationary at the dishwas two tiles were loosed basin sink, tan dried bottom of the sink but drying area identified towards cups, and fan had debris adherof the microwave in the sink but the microwave in the sink but the sink but the microwave in the sink but the sink but the microwave in the sink but the sink bu	ent is not met ion, interview, a ailed to ensure nitary manner contact with hiring meals. Addure kitchen equal regularly, are the kitchen on 1/27/dishwashing rote in the floor with one sing concrete uther. At the triple and warped. It debris was a casin. Observated a fan was blidishes air dryingered to the gual dentified dried of the gual dentified dried of the same contact.	and document e dietary staff and performed gh touch ditionally the uipment and and maintained was properly ew with dietary 21 at 10:08 from had four and one half funder the rubber e basin sink, In the triple dhered to the ution of the dish owing directly from the dish owing directly from the dish owing on racks. The first of the dish owings on the dispings on the	21000	Corrected		
	stove identified the thick white debris w	drip pan unde vith medium bla	r the grill had ack particles on				
	the bottom of the d cabinet next to the along the side of th refrigerator identifier	grill had whitisl e cabinet. Obs ed dried debris	h-gray debris ervation of the on the handles				
	and upper the grill of the serving island basin sitting in it. Be containers with dar	d identified a s elow the sink, t	ink with a black two plastic				

Minnesota Department of Health

STATE FORM 3TCX11 If continuation sheet 8 of 12

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DOILDING.		_	,
		00406	B. WING		01/2	, 7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DADKVII	EW MANOD NUIDGING	308 SHER	MAN AVEN	JE		
PARKVII	EW MANOR NURSING	ELLSWOF	RTH, MN 56	129		
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21000	one of the plastic or chunky debris dried refrigerator identified and upper grill of the she had worked at months and the tile started. The mainted tiles were missing. blower on the dished identified there was place, but the even cleaning at the end. Interview with Cook a.m., verified the hamicrowave door, growere not thoroughly not had a deep cleak itchen island sink used routinely, but staff could drain can was washed daily in unsure who cleaned the sink, and stated quite some time. Eakitchen, while in usclean all the handle end of the night. No presently in place, at least October 20 dietary manager. Since the sink and debris in directly towards the sink and debris in directly towards the sink and stated the sink and debris in directly towards the sink and stated the sink and debris in directly towards the sink and the sink and debris in directly towards the sink and the sink and debris in directly towards the sink and the sink and debris in directly towards the sink and the	trap drain. A strainer was in ontainers and had brown I to it. Observation of the d dried debris on the handles e refrigerator. DA-A identified the facility for about two is had been like that since she enance department was aware She was unsure when the is was last cleaned. DA-A also is no cleaning schedule in ing staff was responsible for	21000	DEFICIENC!)		
	towards the dishes position at the facili had resigned about	C-A had just resumed a ty during the past month, but two months ago due to dietary manager. Prior to				

Minnesota Department of Health

STATE FORM STATE FORM 16899 3TCX11 If continuation sheet 9 of 12

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
, , , , , , , , , , , , , , , , , , , ,	or contribution	BERTH 10/THEIT HEMBERT	A. BUILDING:			
		00406	B. WING		01/2	; 7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARKVII	EW MANOR NURSING	HOME	MAN AVEN			
		ELLSWOF	RTH, MN 56	129		I
(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 SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETE DATE
21000	Continued From pa	ge 9	21000			
	that, she had worked tiles had been crack she could remembe the tiles and the sin plan was to fix them communicate need maintenance depart does not represent old dietary manage and several staff has manager. She only months, but the kitch were not served accommens because the food required to see many substitutions, notify the dietitian of the menus. The kitch cracks, and the starmanager were work practices. Kitchen see the start of the start	ed in the kitchen, and the floor ked and missing for as long as er. Maintenance was aware of k, she was unsure what the in staff used sticky notes to ed repairs in the kitchen to the tment. C-A stated the kitchen what the staff were like. The r 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 er manager would not order the rote the meals. Menus had and the staff continued to f the concerns of not following chen had fallen through the ff and new interim dietary king towards restoring kitchen canitation had not yet been menus were now being				
	at 11:45 a.m., ident during the meal ser commercial sandwi with her gloved han refrigerator, opened condiments, and wi washing her hands	noon meal service on 1/27/21, ified C-A was wearing gloves vice. C-A was serving turkey ches, and handled the bread ds. C-A walked to the d the refrigerator to get thout removing her gloves and she continued to serve bread ds, and served up food trays.				
	verified she had no performed hand hy handles of the refrig been wiped down for	21, at 12:25 p.m., with C-A tremoved her gloves and giene after touching the door gerator. The handle had not ollowing observation of debrised gloves should be removed				

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STATE FORM 6899 3TCX11 If continuation sheet 10 of 12

A. BUILDING: COMPLETED 00406 B. WING 01/27/202	AN OF CORRECTION			
00406 B. WING 01/27/202				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	OF PROVIDER OR SUPPLIER			
PARKVIEW MANOR NURSING HOME 308 SHERMAN AVENUE ELLSWORTH, MN 56129	VIEW MANOR NURSING			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG X	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			
21000 Continued From page 10 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 manager left. Staff were to remove gloves and perform	and hand hygiene per high touch surfaces food served to reside Interview on 12/27/2 identified prior to the the menus were not the menus. The old ordering food according f			

Minnesota Department of Health

STATE FORM 6899 3TCX11 If continuation sheet 11 of 12

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
71101011			WITHOUT NOWIBER.	A. BUILDING:			
		00406		B. WING		C 01/27/2021	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
PARKVII	EW MANOR NURSING	HOME		RMAN AVENI RTH, MN 56			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21000	Continued From partial high tough surfaces Kitchen equipment schedule and betwee kitchen was also to schedule to prevend dietitian also agreed serving island sink removed and any comaintain a sanitary department had maneeded updating. A kitchen sanitation not provided. The 3/4/20, Handw policy identified standoning gloves, and use was not a replaying ene. No policy specific for kitchen SUGGESTED MET The administrator, of designee could reviprocedures related and kitchen sanitation for nursing, or designed ucate staff and densure compliance findings to the Qual Improvement (QAP recommendations to TIME PERIOD FOR (21) days.	s and before was to be cleen meal ser have a deep t food-borne d equipment should be in racked tiles renvironment any outdated a policy was reshing and History of the facility of the facility of the facility of the facility of the ensure one of the ensure one of the ensure one of the end of the ensure one of the ensure one of the ensure one of the end of the ensure one of the ensure one of the end of the ensure one of the end of the ensure one of the end of the ensure of the end of the ensure one of the end of the ensure of the ensure of the ensure of the end of the end of the ensure	eaned on a vices. The ocleaning illnesses. The such as the working order or replaced to the collection of the collection	21000			

6899

Minnesota Department of Health STATE FORM

PRINTED: 03/05/2021 FORM APPROVED OMB NO. 0938-0391

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245553	B. WING				C 27/2021
	PROVIDER OR SUPPLIER			30	REET ADDRESS, CITY, STATE, ZIP CODE 8 SHERMAN AVENUE LLSWORTH, MN 56129	<u>, , , , , , , , , , , , , , , , , , , </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	survey was comple	TS ugh 1/27/21, an abbreviated eted at your facility by the nent of Health to determine if	F 0	000			
	requirements of 42 Requirements for L	ot in compliance with PCFR Part 483, Subpart B, and Long Term Care Facilities.					
	substantiated: H5553009C (MN00 cited at F808 and F	plaints were found to be 0069212) with deficiencies F812 0065168) with deficiencies					
	The following compunsubstantiated: H5553011C (MN00	plaint was found to be					
	as your allegation of Department's acceenrolled in ePOC, at the bottom of the form. Your electron	of correction (POC) will serve of compliance upon the eptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.					
	on-site revisit of yo validate that substate regulations has be your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with					
	CFR(s): 483.25(d)(§483.25(d) Acciden The facility must en	nts.	F 6	889			3/15/21
LABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Electronically 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

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.

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED	
		245553	B. WING			C 27/2021	
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP C			
DADIO//I		IO LIOME		308 SHERMAN AVENUE			
PARKVII	EW MANOR NURSIN	IG HOME		ELLSWORTH, MN 56129			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on intervier facility failed to en assessed and impostaff were trained safe ambulation for Findings include: R3's 12/30/20, qua (MDS) identified Frequired extensive mobility, transfers personal hygiene. Stroke, hemiplegia right side, chronic R3's care plan data fall risk due to have affecting his right have staff assist waccording to there were to ensure R3 keep the bed in the fall risk evaluation and as need. Staff appropriately to er mats beside each	resident receives adequate esistance devices to prevent enteresistance devices to prevent entered when and document review, the sure interventions were elemented to prevent falls and on medical equipment used for or 1 of 3 residents (R3). The entered was intact. R3 assistance of one staff for bed and hemiparesis affecting his pain, and encephalopathy. The entered to prevent falls and on medical equipment used for or 1 of 3 residents (R3). The entered to prevent falls and on medical equipment used for or 1 of 3 residents (R3). The entered to great the entered to use devices as with each new fall, quarterly, if were to use devices as the entered to the ent	F 6	,	veloped for the step to follow when will include the diate to ensure fy family and nge in resident S Coordinator The MDS care plan as ist to be turned sing meeting 021 to educate licy, sining will be iately assist a valker for and education 021. Quarterly procedures red. Audits will esignee and		
	the following: On 12/24/20 at 6:0	20 p.m., R3 was being assisted neal to the rest room with a gait					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245553	B. WING_		01	C / 27/2021	
	PROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP 308 SHERMAN AVENUE ELLSWORTH, MN 56129		12112021	
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From pa	age 2	F 68	39			
	belt, hemi-walker, a slipped and lost his was assisted to the his buttocks and rig the time of the fall. The R3's 12/24/20	and assistance of 1 staff. R3 footing on his right foot and foor by staff. R3 landed on ght arm. R3 had no injures at RMR, care plan and progress					
	notes all lacked evidence of any immediate interventions that were implemented as a result o the 12/24/20 fall.						
	the bathroom while	ress note identified R3 fell in an unidentified NA transferred 3 hit his head on the toilet					
	was being transferi the fall. R3's Post-f of any immediate in	rfall Evaluation identified R3 red to the toilet at the time of fall Evaluation lacked evidence interventions that were result of the 12/24/20 fall.					
	assistant (NA)-B id assistance with trai ambulating. R3 had knee occasionally b	11, at 10:00 a.m. with nursing entified R3 required staff nsfers, toileting, and dright sided weakness, and his buckles when ambulating. He to the floor a few times, but II when.					
	identified R3 was fi the toilet and had b times due to dizzing	11, at 10:03 a.m. with (NA)-B requently dizzy when getting off been lowered to the floor many ess. Also R3's knee buckles he walks, and staff need to be					
		1, at 2:42 p.m., with registered ified R3 had a stroke and used					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245553	B. WING		0	C 1/27/2021
	PROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP COD 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	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	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 training walker. Newer staff to ambulate R3.	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 no on how to use the hemif were not as familiar with how	F 6	89		
	physical therapist (R3 had any falls. Rafter a stroke and hemi-walker and as belt. The PT expected, or had to be lowered him to the evaluation and also knew how to use that hemi-walkers wother equipment. Sto use the hemi was but the restorative appropriately use the	11, at 2:08 p.m. with the PT) identified he had not heard 3 was admitted to the facility had improved enough to use a sistance of 1 staff and a gait sted to be updated if residents wered to the floor so they could be if PT was appropriate. If staff floor, PT would do an cobserve staff to ensure they he hemi walker appropriately ere not used as frequently as staff were not educated on how liker when he was admitted, staff who were trained how to he walker, would have been staff on how to use it				
	director of nursing when staff lowered been contacted, an retrained on transfe techniques for R3 f no additional intervithe falls to prevent	(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 to completed for the fall on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245553	B. WING _		1	C / 27/2021
	PROVIDER OR SUPPLIER	B HOME		STREET ADDRESS, CITY, STATE, ZIP COL 308 SHERMAN AVENUE ELLSWORTH, MN 56129		21/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	8/17/20. Staff were implement interven to complete a fall resection of the election be reviewed by the The DON agreed, is should have been et to ensure R3 used provided the proper and transfer safely. The 10/29/20, Fall I policy was to protect safety. PT was to be evaluate residents of falls, or when a fall resident experience the fall policy. Falls monthly, and during performance impromanagement team pharmacist. Reside were to have more interventions impled Therapeutic Diet Pr CFR(s): 483.60(e)(1) Therapeutic Diet Pr CFR(s): 483.60(e)(1) Therapeutic diet, to law.	to follow the policy and tions to prevent falls, and were export 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 support for R3 to ambulate. Prevention policy identified the extresidents and promote enformed of falls and was to when there were repeated pattern was identified. If a led a fall, staff were to follow were to be evaluated weekly, a quality assurance and evenent meetings with the entered director and ents identified at a high fall risk in-depth prevention mented. The escribed by Physician (1)(2) entic Diets apeutic diets must be	F 68			3/15/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	` '	E SURVEY IPLETED
		245553	B. WING			C
NAME OF E	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	· ·	27/2021
	EW MANOR NURSIN			308 SHERMAN AVENUE ELLSWORTH, MN 56129	<i>)</i> E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 808	Based on observe review, the facility meals were serve for 1 of 1 resident soft diet. Findings include: R4's physician or ordered for a liber diet. R4's diagnost disease. R4's 10/30/20, diecontinued to main continued to main continued to be on natural teeth were continued with che continued with che required a mecha one staff for meal room. During observation 12:15 p.m., C-A scalibrated utensils appropriate portion received half portified she was for green beans in was indicated by the only person on a rekitchen did not prefoods, staff just che was able to eat. Swere trained to preform the service of the servi	ation, interview, and document failed to ensure therapeutic d according to physician orders (R4) prescribed a mechanical ders dated 1/27/21, identified an alized, regular, mechanical soft es included Parkinson's etitian note identified R4 tain a stable weight and a mechanical soft diet. His in poor condition, and he	F 80	Policies will be reviewed and Interim Dietary Manager and I Dietician by 3/15/2021. On Ma mandatory dietary staff meetir held. The Registered Dietician present and education will be appropriate measuring device adequate portions are being s according to the menu and als will be provided on how to pre mechanically soft diet. The int manager will be attending a so class on March 9, 2021. Mont and quarterly x1 will be compl Registered Dietician or design ensure diet orders are correct to the MAR and followed by di Audits will be brought to the faquarterly QA meeting.	Registered arch 10, a and will be or will be provided on some to ensure erved so education pare a erim dietary erve-safe hly audits x3 eted by according etary staff.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
		245553	B. WING _		ı	C 27/2021	
	PROVIDER OR SUPPLIER	B HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 308 SHERMAN AVENUE ELLSWORTH, MN 56129	1 01/	2172021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 808		ge 6 d been serve-safe certified at vas many years ago before	F 80	80			
	working in the facility working in the facility's fall and 9/20/20, by the diet provide ground mean according to the mean according to the menu, and nurstrained to prepare redietitian came to the audits and observe administrator verifical safe certified in the						
	dietary manager ce A policy was reques provided for dietary Food Procurement, CFR(s): 483.60(i)(1 §483.60(i) Food sat The facility must -	rtification once hired. sted, but no policy was staff training. Store/Prepare/Serve-Sanitary)(2)	F 81	12		3/15/21	
	approved or consid state or local author (i) This may include	ered satisfactory by federal, rities. food items obtained directly s, subject to applicable State					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245553	B. WING _			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI		2112021
				308 SHERMAN AVENUE		
PARKVI	EW MANOR NURSING	G HOME		ELLSWORTH, MN 56129		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
IAG	REGOLATOR OR	DENTI TING IN GRAWATION,	IAG	DEFICIENCY)	TROTTUTE	
F 812	Continued From page (ii) This provision of facilities from using gardens, subject to safe growing and f (iii) This provision of from consuming for S483.60(i)(2) - Store from consuming for from consuming from consumi	age 7 loes not prohibit or prevent g produce grown in facility o compliance with applicable ood-handling practices. does not preclude residents ods not procured by the facility. re, prepare, distribute and rdance with professional	F 8	DEFICIENCY)	revised by Registered a mandatory Registered n on hand d storage of ssional ely. Menus g the A cleaning and staff es. Interim ling the 2021. The by on the floor e replaced x3 and by liee to make Audits will	
	towards cups, and fan had debris adh of the microwave ic bottom of the micro	dishes air drying on racks. The ered to the guard. Observation dentified dried drippings on the bwave door. Observation of the drip pan under the grill had		J 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	9	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		LE CONSTRUCTION		E SURVEY PLETED
						(0
		245553	B. WING	·		01/2	27/2021
	PROVIDER OR SUPPLIER	G HOME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 808 SHERMAN AVENUE ELLSWORTH, MN 56129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	thick white debris we the bottom of the dicabinet next to the along the side of the refrigerator identifies and upper the grill of the serving island basin sitting in it. But containers with dark placed under the Poone of the plastic or chunky debris dried refrigerator identifies and upper grill of the she had worked at months and the tile started. The mainted tiles were missing blower on the dished identified there was place, but the even cleaning at the end. Interview with Cook a.m., verified the had microwave door, gray were not thoroughly not had a deep cleak itchen island sink used routinely, but staff could drain ca was washed daily in unsure who cleaned.	with medium black particles on rip pan. The side of the pan grill had whitish-gray debris e cabinet. Observation of the ed dried debris on the handles of the refrigerator. Observation didentified 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 to it. Observation of the ed dried debris on the handles are refrigerator. DA-A identified the facility for about two is had been like that since she enance department was aware She was unsure when the es was last cleaned. DA-A also is 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, fill drip pan, and pan cabinet by cleaned. The kitchen had an allow drain and was not the basin was in the sink so need vegetables. The basin in the dishwasher. She was dishe plastic containers under	F	812			
	quite some time. Eakitchen, while in usclean all the handle end of the night. No	If they have been like that for each shift was to clean up the e, and the evening shift was to es and high touch areas at the cocleaning schedule were and had not been place since					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245553	B. WING				27/ 2021
	PROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 08 SHERMAN AVENUE LLSWORTH, MN 56129	1 0172	21/2021
(X4) ID PREFIX TAG	(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	at least October 20 dietary manager. S drip pans when the the fan had debris i directly towards the unaware that the fat towards the dishes. position at the facili had resigned about differences with the that, she had worke tiles had been crac she could remembe the tiles and the sin plan was to fix then communicate need maintenance depardoes not represent old dietary manage and several staff hamanager. She only months, but the kito were not served ac menus because the food required to set many substitutions, notify the dietitian of the menus. The kito cracks, and the staff manager were world practices. Kitchen saddressed, but the followed.	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 a drying dishes. She was in was not supposed to point. C-A had just resumed a sty during the past month, but it two months ago due to a dietary manager. Prior to ad in the kitchen, and the floor ked and missing for as long as a ser. Maintenance was aware of a staff used sticky notes to ed repairs in the kitchen to the staff used sticky notes to ed repairs in the kitchen to the themat. C-A stated the kitchen what the staff were like. The rewas not able to do the job, and quit during the time she was worked at the facility for a few then was in bad shape. Menus cording to the dietitian's a manager would not order the reve the meals. Menus had and the staff continued to find the concerns of not following then had fallen through the fand new interim dietary king towards restoring kitchen anitation had not yet been menus were now being	F 8	312			
	at 11:45 a.m., ident during the meal ser	ified C-A was wearing gloves vice. C-A was serving turkey ches, and handled the bread					

with her gloved hands. C-A walked to the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245553	B. WING _		01	C /27/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 308 SHERMAN AVENUE ELLSWORTH, MN 56129	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 812	condiments, and washing her hands with her gloved had linterview on 12/27 verified she had not performed hand his handles of the refribeen wiped down on them. C-A agree and hand hygiene high touch surface food served to resulterview on 12/27 identified prior to the menus. The oldordering food accompany or dietary manager rowith orders until ship process, but the distaff were also not time between Octo 2021. The schedulor dietary aid schedulor dietary aid schedulor dietary manager rowith orders until ship process, but the distaff were also not time between Octo 2021. The schedulor dietary aid schedulor dietary	ed the refrigerator to get without removing her gloves and so, she continued to serve bread ands, and served up food trays. 1/21, at 12:25 p.m., with C-A but removed her gloves and agiene after touching the door igerator. The handle had not following observation of debrished gloves should be removed performed after contact with its and before direct contact with its and before direct contact with idents. 1/21, at 12:47 p.m., with C-B he old dietary manager leaving, but being followed according to dietary manager was not ording to the menu and the incorrect food. She had not a week in advance as had been ure prior to her taking the ble. Staff offered to assist her he was familiar with the itetary manager refused help. It scheduled correctly during the ober 2020, and mid January le would often not have a cook duled, and staff would have to shifts. Many staff resigned,		2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245553	B. WING_			C / 27/2021
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 308 SHERMAN AVENUE ELLSWORTH, MN 56129	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 812	kitchen staff, hower manager deleted in vacating the position with the previous of follow-through, and the right person for confirmed the mere and staff alerted the substitutions being the first issue correleft. Staff were too hand hygiene any high tough surface Kitchen equipment schedule and between the substitutions being the first issue correleft. Staff were too hand hygiene any high tough surface Kitchen equipment schedule and between the schedule to preve dietitian also agrees serving island sink removed and any maintain a sanitar department had maintain a sanitar departme	ever one of the former dietary many documents prior to on. There were also concerns dietary manager regarding d that person was simply not or the job. The dietitian hus were not being followed, he dietitian of the many g made. Following menus was ected after the dietary manger remove gloves and perform time they made contact with es and before serving food. It was to be cleaned on a ween meal services. The o have a deep cleaning not food-borne illnesses. The ed equipment such as the contact with estand be in working order or cracked tiles replaced to y environment. The dietary many outdated policies that washing and Hand Hygiene aff were to wash hands before affected for performing hand was provided for hand hygiene	F 8	12		