Electronically delivered
December 14, 2021

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

RE: CCN: 245553
Cycle Start Date: October 14, 2021

Dear Administrator:

On November 15, 2021, we informed you of imposed enforcement remedies.

On December 1, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 15, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 15, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 15, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of November 15, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 15, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us

Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 14, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING _____ B. WING _____	C 12/01/2021

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
F 000	INITIAL COMMENTS On 11/29/21 through 12/1/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5553014C (MN78807), with a deficiency cited at F695. The following complaint was found to be UNSUBSTANTIATED: H5553015C (MN77788), however, related deficiencies were cited at F607 and F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		12/23/21

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

Electronically Signed | 12/22/2021

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

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F 607	Continued From page 1 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to prohibit 1 of 1 staff (nurse aide (NA)-B) from working after allegations of abuse for 1 of 3 residents (R2) was made pending completion of the investigation. Findings include: Review of the 10/19/21 at 12:13 p.m., report to the State Agency (SA) identified on 10/18/21 at around 6:30 a.m., NA-B was reported to have walked into R2's room and stated, "get your own [expletive] breakfast... you're too lazy". Registered nurse (RN)-B left a noted under the director of nursing (DON) door. The DON and licensed social worker (LSW) interviewed R2 and asked for a description of the NA in question. R2 then recalled the name of NA-B. There was no indication NA-B was suspended pending investigation. Review of the 10/21/21, 5 day investigation results identified the facility interviewed multiple residents and staff. No concerns were noted. NA-B denied the allegation but subsequently put in her 2 weeks notice on 10/20/21. There was no indication the facility suspended NA-B from working 10/20/21 through 10/21/21, pending the completion of the investigation. Review of R2's 10/1/21, quarterly Minimum Data Set (MDS) assessment identified intact cognition	F 607	F607 Develop / Implement Abuse / Neglect Policies Immediate Corrective Action: Facility will begin immediately suspending employees who are accused of abuse or neglect as is outlined in Parkview Manor's Vulnerable Adults Protection Plan. R-2's allegation was reported, law enforcement notified, facility conducted investigation, law enforcement conducted investigation. NA-B put in her notice after she was questioned by law enforcement. She has since requested to remain on the schedule as PRN. She will be provided with VA Reporting / Abuse and Neglect training. She will also be provided with a copy of the updated facility Vulnerable Adult Protection Plan / Abuse Policy. Corrective Action as it applies to others; Parkview manor Vulnerable Adult Protection Plan / Abuse Policy was reviewed and updated to include 2 hour reporting requirement. All staff will be provided with a copy of this updated policy.	

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F 607	Continued From page 2 with no documented behaviors. R2 had a diagnosis of stroke with hemiplegia (paralysis) of his right dominate side. R2 required extensive assistance with bed mobility, for transfers, with walking in his room, with locomotion off the unit, with dressing, toileting, and personal hygiene, and required supervision for eating. Review of R2's current, undated care plan identified he was able to communicate and make himself understood and be understood by others. Review of NA-B's time clock and schedule identified she worked on 10/20/21 and again on 10/21/21 as scheduled. Interview on 11/29/21 at 4:30 p.m. with the DON identified she had received a note from RN-B that was placed under her office door on 10/19/21, at around 8:00 a.m.. The note was from from RN-B. The DON and the LSW had gone to R2's room to interview him. R2 described the incident which occurred on 10/18/21 at around 6:30 a.m., and discovered the staff name to be NA-B. Once questioned by the administrator on the allegations, NA-B resigned her position. The administrator had decided not to initiate disciplinary action for NA-B due to her submission of her notice of resignation on 10/20/21. Interview on 11/30/21 at 2:26 p.m., with the administrator identified he had completed the investigation with the assistance of both the LSW and DON. After receiving R2's allegation, he had obtained statements from R2 and NA-B. Law enforcement was notified and interviewed both R2 and staff members on 10/20/21. The administrator planned to provide education to NA-B, however did not as she became upset after	F 607	The Administrator, DON, and Social Worker will be educated on the need to ensure that any accused employee is notified and suspended immediately without pay until investigation is complete when an allegation is made against them. Date of Compliance: 12/23/2021 Recurrence will be prevented by: Administrator, DON, and Social Worker will be educated on the need to ensure that any accused employee is notified and suspended immediately without pay until investigation is complete when an allegation is made against them. The Administrator will monitor by reviewing all new VA reports 1x weekly x3 months, or upon the filing of any VA report for the next 3 months to ensure that they were reported in a timely manner and that any employee accused had been suspended until the conclusion of an investigation. The results will be shared with the QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator	

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F 607	Continued From page 3 speaking with her and handed in her resignation. The administrator confirmed no follow up education or review of abuse, reporting, or VA information was provided to facility staff and NA-B was not suspended pending investigation. He agreed facility policy was not followed. Interview on 11/30/21 at 11:08 a.m., with NA-B identified she had worked overnight on 10/18/21, and left at 6:30 a.m. on that day. R2 had requested pain medication and the nurse had directed her to tell R2 it was not time for his medication, which "made him mad". R2 had requested his breakfast at 6:00 a.m.. R2 was reminded the kitchen did not have anything ready at that time. NA-B identified she had told R2 he should "go to the dining room and get his own breakfast". NA-B agreed she should have chosen her words in a different manner as not to be perceived in an abrasive manner. NA-B stated that was not her intent. NA-B continued to work after the allegation was made on 10/20/21 and 10/21/21. NA-B confirmed she had not been re-educated after the incident. Interview on 12/1/21 at 12:22 p.m., with DON identified she agreed the facility failed to prevent further potential verbal abuse pending an investigation when NA-B was not immediately suspended from work. Review of the 9/30/20 facility policy Vulnerable Adult Protection Plan dated identified if an employee was identified as the alleged perpetrator they were to be notified of the alleged incident and suspended without pay until the investigation was completed.	F 607		
F 609 SS=D	Reporting of Alleged Violations	F 609		12/23/21

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F 609	Continued From page 4 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to timely report allegations of verbal abuse immediately but no later than 2 hours for 1 of 1 resident (R2). Findings include:	F 609	F609 Reporting of Alleged Violations Immediate Corrective Action: NA-B will be provided with VA Reporting / Abuse and Neglect Training. She will also be provided with a copy of the updated	

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F 609	Continued From page 5 Review of the 10/19/21 at 12:13 p.m., report to the State Agency (SA) identified on 10/18/21 at around 6:30 a.m., NA-B was reported to have walked into R2's room and stated, "get your own [expletive] breakfast... you're too lazy". There was no mention if staff had reported the incident to management or the SA timely. Interview on 11/29/21 at 4:30 p.m. with the DON identified she had received a note from registered nurse (RN)-B that was placed under her office door on 10/19/21, at around 8:00 a.m., The DON agreed all allegations of abuse are to be reported immediately but no later than 2 hours to the SA. The DON confirmed no re-education to staff on reporting requirements was conducted. Review of the 10/21/21, 5 day investigation results indicated the facility failed to recognize the late reporting and take steps to prevent reoccurrence by re-educating staff to policies and procedures. Interview on 11/30/21 at 2:26 p.m., with the administrator identified he had completed the investigation with the assistance of both the LSW and DON. After receiving R2's allegation, he had obtained statements from R2 and NA-B. Law enforcement was notified and interviewed both R2 and staff members on 10/20/21. The administrator planned to provide education to NA-B, however did not as she became upset after speaking with her and handed in her resignation. The administrator confirmed no staff had received re-education for abuse reporting. He agreed facility policy was not followed. Interview on 11/30/21 at 11:08 a.m., with NA-B identified she had worked overnight on 10/18/21,	F 609	facility Vulnerable Adult Protection Plan / Abuse Policy. Administrator, DON, Social Worker, and all charge nurses were provided with education on proper VA reporting guidelines. Corrective Action as it applies to others: Parkview Manor Vulnerable Adult Protection Plan / Abuse Policy was reviewed and updated to include the 2 hour reporting requirement. All Staff will be provided with a copy of this updated policy. The charge nurses, DON, Social Worker, and Administrator were educated on proper VA reporting requirements. Date of Compliance: 12/23/21 Recurrence will be prevented by: Charge nurses, DON, Social Worker, and Administrator were educated on proper VA reporting requirements. Charge Nurses will be trained in personally reporting incidents rather than informing DON/Admin to increase the number of facility staff with knowledge of how to report incidents and with training in how / when / what to report. Nursing staff will add VA Reporting Check-In's to regular report meeting agenda at the end of every shift which will be reviewed by DON / Admin.	

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F 609	Continued From page 6 and left at 6:30 a.m. on that day. R2 had requested pain medication and the nurse had directed her to tell R2 it was not time for his medication, which "made him mad". R2 had requested his breakfast at 6:00 a.m.. R2 was reminded the kitchen did not have anything ready at that time. NA-B identified she had told R2 he should "go to the dining room and get his own breakfast". NA-B agreed she should have chosen her words in a different manner as not to be perceived in an abrasive manner. NA-B stated that was not her intent. NA-B continued to work after the allegation was made on 10/20/21 and 10/21/21. NA-B confirmed she had not been re-educated after the incident. Review of the 9/30/20, Vulnerable Adult Protection Plan policy identified staff were to report the allegation to the administrator immediately but no later than 2 hours after forming the suspicion. There was no mention a report was required to be made to the SA within 2 hours.	F 609	The Admin / DON will monitor weekly using Staff VA Reporting Requirements quiz tool. Admin / DON will audit 5 staff at random weekly x4 and then monthly x2 months to ensure compliance. The results will be shared with the QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator / DON / Designee	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 695	F695 Respiratory / Tracheostomy Care	12/23/21

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F 695	Continued From page 7 facility failed to ensure oxygen therapy was appropriately administered for 1 of 1 resident (R1) who required continuous oxygen. Findings include: R1's 8/5/21, admission Minimum Data Set (MDS) assessment, identified R1 had intact cognition and required extensive assistance with most Activities of Daily Living (ADL). R1's had a diagnosis of congestive heart failure, history of hypoxia (low blood oxygenation) and COVID-19. R1 required oxygen therapy. R1's 10/14/21, physician's orders identified R1 had a order dated 8/4/21, which noted R1 was to have continuous oxygen at 2 liters(L)/minute. Interview on 11/29/21 at 3:07 p.m., with family member (FM)-A identified on 11/23/21, she had received messages on her phone from R1 who was "in a panic". R1 texted the facility had "turned off her air". FM-A called the facility and spoke to an unidentified nurse. The nurse reportedly advised FM-A she would go and check on her. FM-A identified she had received messages on her phone from R1 at 4:25 p.m., 4:31 p.m., 4:34 p.m., 4:35 p.m., 4:40 p.m., 4:51 p.m., and the final message at 5:04 p.m.. FM-A identified FM-B had also received three panicked calls from R1, and had finally been able to speak with someone at the facility at 5:14 p.m.. FM-A identified she called R's room at 5:26 p.m. and spoke with R1 who identified nursing assistant (NA)-A was in the room, and got her air back on. FM-A spoke with NA-A who identified the oxygen concentrator was off and "must have accidentally gotten bumped". FM-A identified she believed R1's oxygen was off for at least 30 minutes, and	F 695	and Suctioning Immediate Corrective Action: R1's care plan was reviewed. All CNA and Nursing Staff were provided with oxygen Administration and Safety Training. Medical Gas Training program was implemented for all new Nursing / CNA hires. Corrective Action as it applies to others: Oxygen Concentrator Policy was reviewed and updated to specify that staff administering oxygen must ensure that oxygen is properly connected and flowing. Oxygen Therapy Policy was reviewed and remained current. Portable Oxygen Policy was reviewed and remained current. All CNAs and Nursing Staff were provided with oxygen Administration and Safety Training. Date of Compliance: 12/23/2021 Recurrence will be prevented by: Audits of 5 residents who use oxygen will be conducted weekly x4 and then monthly x2 months to ensure that oxygen tanks are being properly secured. The results will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Audits will be conducted 1x per month x3 months of all new Nursing / CNA hires to	

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	245553	A. BUILDING _____ B. WING _____	C 12/01/2021

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F 695	Continued From page 8 put back on between 5:04 p.m. to 5:14 p.m.. Interview on 11/29/21 at 3:36 p.m., with R1 identified her oxygen had gotten turned off and she was not certain what happened but was not aware of it having occurred previously. R1 identified she had turned on her call light, but no one came. R1 stated staff are usually good about coming when she turned on her call light and was not aware of why no one responded. R1 stated she had "heart trouble" and she was afraid she would not be able to breathe if she did not have her oxygen. Interview on 11/30/21 at 3:21 p.m., with registered nurse (RN)-A identified she was working the evening shift on 11/23/21 and had gone into R1's room that evening to replace R1's water container. The bubbler connector failed to fit the concentrator, so RN-A left the room to retrieve a different connector. RN-A was interrupted before she was able to return with the correct connector. A short time later, NA-A alerted RN-A that R1 was short of breath. NA-A asked RN-A if she could turn R1's oxygen (O2) back on. RN-A stated "yes". R1's oxygen tubing had become disconnected. RN-A assessed R1 and found her oxygen saturation level (SpO2) to be within normal limits at 99% (normal 95-100%). R1 had not complained of difficulty breathing or shortness of breath at the time of her assessment. R1 received oxygen continuously at 2 L/min and was able to have it off while showering and/or intermittently if desired. RN-A agreed she should have returned immediately to R1's room so the oxygen concentrator was connected appropriately or assigned another staff to perform that task. Interview on 11/30/21 at 4:44 p.m., with NA-A	F 695	ensure that they have received Medical Gas Training upon hire. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator / DON / Designee	

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F 695	Continued From page 9	F 695		

identified she had begun answering call lights on 11/23/21. As she went down the hall, she saw R1's call light was on. When she entered R1's room, R1 stated she had been left without her oxygen on. NA-A left to ask advised RN-A R1's oxygen was not on. RN-A agreed NA-A could hook up the equipment and would be down to assess R1. NA-A immediately returned to R1's room and ensured R1's concentrator was set up appropriately and turned on. RN-A then came in to assess the resident.

Interview on 11/30/21 at 10:45 a.m., with the director of nursing (DON) identified she had not provided any education to all staff as she was waiting for the administrator to decide if additional education was indicated. The DON's expectation was staff were to make certain oxygen was connected and working prior to leaving a resident room and to check periodically during the shift to ensure residents were receiving oxygen as ordered.

Review of the undated, Oxygen Therapy policy identified residents were to be administered oxygen as ordered.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 14, 2021

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

Re: Event ID: VMVR11

Dear Administrator:

The above facility survey was completed on December 1, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

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	00406	A. BUILDING: _____ B. WING _____	C 12/01/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/29/21 through 12/1/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5553014C (MN78807), however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5553015C (MN77788). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		