DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VW3H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00543

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245475**
2.STATE VENDOR OR MEDICAID NO.
(L2) **224840900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW HOME**
(L4) **102 COUNTY STATE AID HIGHWAY 9**
(L5) **BELVIEW, MN** (L6) **56214**

4. TYPE OF ACTION: 2 (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/11/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **30** (L18)
13.Total Certified Beds **30** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

Date :
Nicole Osterloh, Supervisor 12/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 12/12/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245475

December 12, 2018

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 3, 2018 the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2018

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

RE: Project Number S5475031

Dear Administrator:

On November 9, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on October 24, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 11, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 7, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 24, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 3, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2018, effective December 3, 2018 and therefore remedies outlined in our letter to you dated November 9, 2018, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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5. Validation **6. Complaint**
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8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/24/2018** (L34)

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2 AOA 3 Other

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And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **B*** (L12)

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	30			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Laura Ducharme, HFE NE II 11/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 11/27/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
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INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
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00-Active

28. TERMINATION DATE:
(L28)

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03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

November 9, 2018

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

RE: Project Number S5475031

Dear Administrator:

On October 24, 2018, a standard survey was completed at your facility by the Minnesota Department(s) 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 3, 2018.

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.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the 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) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by January 24, 2019 (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 April 24, 2019 (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:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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
	245475	A. BUILDING _____ B. WING _____	10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	**102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on October 22-24, 2018 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for	E 024		12/3/18

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

Electronically Signed | 11/16/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING _____ B. WING _____	10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	**102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 024	Continued From page 1 integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure their emergency preparedness policies and procedures addressed the use of volunteers in an emergency. Findings include: Review of the facility's current Emergency Preparedness plan/ policy revealed no plan had been developed for the potential need to utilize volunteers in an emergency. During an interview on 10/24/18, at 10:30 a.m. the administrator verified there were no provisions in the emergency plan to include volunteers but would update the plan to include them.	E 024	E024 EMERGENCY PREPAREDNESS PLAN: POLICIES/PROCEDURES - VOLUNTEERS AND STAFFING: Based on interview and policy review, the facility failed to ensure their emergency preparedness policy and procedures addressed the use of volunteers in an emergency. Review of the Emergency Preparedness Plan/Policy revealed no plan had been developed for the potential need to utilize volunteers in an emergency. ACTION: Facility Administrator will develop a policy and procedure for use of volunteers: 1.Parkview Home will utilize volunteers to assist staff during an emergency situation. Volunteers would be placed on the volunteer list, after completion of a background check and after having received training in various tasks that would be required in an emergency. 2.Volunteers who have a medical background would have their license verified. Medical volunteers would need to provide care to residents within their scope of practice. Non-medical volunteers would be allowed to perform non-medical tasks. 3.Volunteers would share with the facility, all phone contact numbers and e-mail addresses. All information would be placed on the "Volunteer Contact Roster."	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
E 024	Continued From page 2	E 024	4.Volunteers would be placed on a tracking roster when they arrive on the scene and begin working with facility staff to provide care. 5.Volunteers would be asked to participate in all facility disaster exercises. 6.Policies and procedures would be completed by Administrator. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: ADMINISTRATOR	
F 000	INITIAL COMMENTS On 10/22/18 through 10/24/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		12/3/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 3 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 4 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

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	245475	A. BUILDING _____ B. WING _____	10/24/2018

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F 623	Continued From page 5 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the ombudsman of facility-initiated discharges for 1 of 1 resident (R27) who was discharged to the hospital. Findings include: R27's admission record indicated the resident was admitted to the facility on 10/29/14, with diagnoses including: osteoarthritis, chronic atrial fibrillation (irregular heart beat), anemia (low blood levels), dementia, and stage 4 chronic kidney disease. R27's progress notes dated 9/25/18, indicated the resident had a change in condition; jerky movements, seizure like activity, and was not acting like her normal self. The note indicated an ambulance took R27 to the emergency room at 3:50 p.m. and that R27 was admitted to the hospital where she stayed, and was subsequently discharged from the facility.	F 623	Facility failed to notify the ombudsman of facility-initiated discharges for 1 of 1 residents (R27) who was discharged to the hospital. It is the policy of Parkview Home to notify the ombudsman of any facility-initiated discharge. Resident R27 was identified during the survey as being affected by this deficiency due to her transfer records having no documentation of notification of transfer to the hospital to the ombudsman. DON obtained forms from Redwood Area Hospital that were sent to the hospital with the resident. The notice of transfer/discharge was filled out and sent with the resident, but had not been sent to the ombudsman. ACTION:To prevent further recurrences of	

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F 623	Continued From page 6 During interview on 10/23/18 in the afternoon, the director of nursing (DON) stated staff had been unable to locate documentation confirming whether the facility had notified the ombudsman of R27's facility initiated transfer and her subsequent discharge. The facility's Bed Hold and Return to Facility policy and Bed Hold Notification/Election policy last reviewed on 8/31/18, did not address notification of the ombudsman following a facility initiated discharge.	F 623	this deficiency, DON met with the licensed nurses who were involved in the transfer of Resident R27 to review the deficiency and our current facility policy. Following notification of this deficiency, during the survey process, a copy of the Notice of Transfer or Discharge Form was faxed to the ombudsman that day. The Transfer Packets that are provided for licensed nurses transferring residents out of the facility were reviewed by the DON. In addition to the Transfer Checklist, ED Communication Form, Bed Hold Election Form (and Policy), Notice of Transfer or Discharge Form contained in the packet, DON also added the fax cover form used to send notification to the ombudsman. DON will be addressing and reviewing the Transfer and Discharge From the Facility Policy with all licensed nursing staff at the next nurse's meeting on 11/28/18. DON will be regularly auditing all transfer documents as residents are transferred out to ensure the facility policy and procedure is being completed. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: DIRECTOR OF NURSING	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the	F 625		12/3/18

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F 625	Continued From page 7 nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bed hold notification was provided for 1 of 1 resident (R27) reviewed for hospitalization. Findings include: R27's admission record indicated the resident was admitted to the facility on 10/29/14, with diagnoses including: osteoarthritis, chronic atrial fibrillation (irregular heart beat), anemia (low blood levels), dementia, and stage 4 chronic kidney disease.	F 625	Facility failed to ensure bed hold notification was provided for 1 of 1 residents (R27) who was discharged to the hospital. It is the policy of Parkview Home to inform and provide in writing to the resident and/or the resident's representative the facility bed hold and return to the facility policy at the time of transfer or leave of absence specifying the duration of the bed hold policy. Resident R27 was identified during the	

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F 625	Continued From page 8 R27's progress notes dated 9/25/18, indicated the resident had a change in condition; jerky movements, seizure like activity, and was not acting like her normal self. The note indicated an ambulance took R27 to the emergency room at 3:50 p.m. and that R27 was admitted to the hospital where she stayed, and was subsequently discharged from the facility. During interview with the Director of Nursing (DON) during the afternoon of 10/23/18, the DON stated staff were unable to locate R27's bed hold form or any other documentation confirming the facility had provided a bed hold notification to R27 or the responsible party when R27 was discharged to the hospital. The facility's Bed Hold and Return to Facility policy last reviewed 8/31/18, included: "the objective of giving a bed hold is to ensure the resident is informed of the State's bed hold duration, payment, and their right to return to the facility from a hospitalization or therapeutic leave." In addition, the policy included: "will give written information per the bed hold policy and bed hold election form to the resident or resident representative before the resident is transferred to a hospital or the resident goes on therapeutic leave." The facility's Bed Hold Notification/Election policy last reviewed on 8/31/18, indicated the nurse was to "obtain the Bed Hold Policy and Return to Facility notice and provide the notice to the resident and/or their representative at the time of transfer or leave of absence. The nurse will ensure that a copy of the notice accompanies the resident as the resident leaves the facility. The nurse will document the provision of the Bed Hold	F 625	survey as being affected by this deficiency due to her transfer records having no documentation regarding the facility bed hold policy and return to facility notice. DON obtained records from Redwood Area Hospital that were sent to the hospital with the resident. The bed hold election form was in the packet and was sent to the hospital with the resident, but was not completed. There was no documentation that the resident or family were verbally notified of the bed hold policy/procedure. ACTION: To prevent further recurrences of this deficiency, DON met with the licensed nurses who were involved in the transfer of resident R27 to review the deficiency and our current facility policy. The Transfer Packets that are provided for licensed nurses transferring residents out of the facility were reviewed by the DON. The forms in the packet include the Transfer Checklist, ED Communication Form, Bed Hold Election Form (and Policy), Notice of Transfer or Discharge Form and fax cover form to send notice to the ombudsman (correction of FTag 623). DON will be addressing and reviewing the Bed Hold and Return to Facility Policy and the Bed Hold Notification/Election Form with all licensed nursing staff at the next nurse's meeting on 11/28/18. DON will be regularly auditing all transfer documents as residents are transferred out to ensure the policy and procedure is being followed. COMPLETION DATE: 12/3/18	

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F 625	Continued From page 9 Policy and Return to Facility notice to the resident and the information give to the representative in the resident's record."	F 625	RESPONSIBLE PERSON: DIRECTOR OF NURSING	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications available for use were appropriately labeled, and failed to ensure the medications had not expired, for 3 of 14 residents (R8, R12 and R14)whose	F 761	Facility failed to ensure medications available for use were appropriately labeled, and failed to ensure the medications were not expired, for 3 of 14 residents (R8, R12, and R14) whose	12/3/18

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F 761	Continued From page 10 medication containers were reviewed. Findings include: During an observation on 10/23/18 at 1:25 p.m., licensed practical nurse (LPN)-B was observed to be administering medications. It was observed R14's blisterpack of Tramadol 50 milligram (mg), was labeled to administer 1 tablet every 4-6 hours as needed (PRN). The electronic medication administration record (EMAR) order indicated Tramadol 50 mg was to be given 1 tablet, three times per day (TID). During observation in R12's room on 10/23/18 at 1:35 p.m., R12 had a bottle of acetaminohen 325 mg, available for use. The label on the bottle indicated an expiration date of 6/30/18. During observation in R8's room on 10/23/18 at 1:45 p.m., an open botttle of acetaminophen was observed. The label on the bottle indicated an expiration date of 4/19/18. During interview on 10/24/18 at 8:05 a.m., LPN-B stated it was the nurse's responsibility to check resident rooms for expired medications weekly. LPN-B also stated when there were discrepancies between a medication label and the EMAR, staff were to verify the order and call the pharmacy to report the need for an updated label. During interview on 10/24/18 at 8:27 a.m., the DON stated staff were expected to periodically check for expired medications. The DON said if a medication label did not match a physician's order, staff should verify the correct dose and notify the pharmacy so staff could ensure	F 761	medication containers were reviewed. It is the policy of Parkview Home to ensure that residents have their medications administered in a safe, timely manner by staff trained to administer medications and that all medications are appropriately stored and labeled. On 10/23/18, Resident R14 was noted to have a blisterpack of Tramadol 50 mg which was labeled to administer "1 tablet every 4-6 hours as needed PRN." The EMAR order indicated the Tramadol order had been changed to "1 tablet, 50 mg, TID." Resident R12 had a bottle of acetaminophen available for use with an expiration date of 6/;30/18. Resident R8 had a bottle of acetaminophen available for PRN use with an expiration date of 4/19/18. ACTION: Following notification of the expired medications and incorrect label, DON removed the expired medications from the resident's medication cupboards and corrected the Tramadol order and placed the correct sticker on the blisterpack label. To prevent further recurrences of this deficiency, DON met with licensed nurses who were working during the survey. They verbally were able to state the correct procedure for checking expiration date when reordering medications and for application of the colored sticker to be used on the label for medication orders that have changed. DON reviewed the medication administration policy and procedure and	

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F 761	Continued From page 11 medications are administered correctly. Review of the facility's 4/20/17, Medication Administration policy, indicated staff were to verify the resident's name, physician, name of medication, dosage of medication, form of medication, frequency of administration, quantity of medication, and specific instructions for administration. There was no mention of how labels should be maintained, or how staff were to monitor for expired medication.	F 761	revised the policy to include the following procedural tasks: each nurse will check all medications for expiration dates when reordering medications weekly on Mondays; any expired medications will be removed from the resident's medication cupboard and taken to the medication room for proper destruction and disposal; if an order is changed, the nurse processing the order will notify the pharmacy of the change, request a new label if appropriate and will affix the correct sticker to the label to alert other nursing staff of the change. DON will be regularly auditing medication cupboards weekly for 4 weeks, then monthly when the consulting pharmacist is here for rounds, as the pharmacist also audits for these issues during each monthly visit. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: DIRECTOR OF NURSING	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		12/3/18

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F 812	Continued From page 12 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 staff (Cook-A, NA-A, LPN-C and RN-B) utilized gloves appropriately and performed hand hygiene when appropriately during the meals on 10/22/18 and 10/23/18. Findings include: During observation of kitchen food service on 10/23/18 at 12:53 p.m., meal cards indicating resident dining needs were observed at each residents' table prior to the meal service. During the observation, as residents made their dinner choices, facilty staff brought the meal cards to the food service window. Cook -A would then use those meal cards to dish up each resident's meal. Cook-A was observed grabbing an unidentified resident's meal card with her gloved hand and when cook-A had verified the diet order, she was observed to reach into the hamburger bun bag to retreive a bun. After the meal was served, the meal card was taken back to the unidentified resident's table where it remained until the end of the meal. During observations in the dining room on	F 812	Facility failed to ensure 4 staff (Cook A, NA-A, LPN-C, RN-B) utilized gloves appropriately and performed hand hygiene when appropriate during meal service on 10/22/18 and 10/23/18. It is the policy of Parkview Home to ensure that staff serving food and providing food service for residents is safeguarding the health and well-being of residents by preventing foodborne illnesses and ensuring that all foods are served in a sanitary manner. On 10/23/18, meal cards indicating resident dietary needs were noted to be at each resident's table prior to the meal service. As residents made their choices, facility staff brought the meal cards to the food service window. Cook-A would then use those meal cards to dish up each resident's meal. Cook-A was observed grabbing an unidentified resident's meal card with her gloved hand, verifying the diet order, reaching into the hamburger bun bag to retrieve a bun, then returning the meal card to the facility staff member. The staff member then returned the card to the unidentified resident's table.	

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F 812	Continued From page 13 10/22/18 at 5:24 p.m. and again at 5:33 p.m., nursing assistant (NA)-A was noted to be scratching her head, leaning her face on her hand, and rubbing her ear. NA-A was not observed to sanitize her hands appropriately before continuing to feed R18 During observation on 10/22/18 at 5:35 p.m., licensed practical nurse (LPN)-C was observed in the dining room serving meals to the residents. LPN-C was observed to use her two-way radio and to place it into her pocket. LPN-C continued to serve meals and set up flatware without changing her gloves or sanitizing her hands. During observation on 10/22/18 at 5:41 p.m., registered nurse (RN)-B was observed to assist R7 to eat. Duriing the observation, RN-B was observed to scratch and rub her neck then proceeded to hold R7's drinking glass for the resident, without performing hand hygiene. During interview with the dietary manager (DM) on 10/24/18 at 9:15 a.m., the DM stated it was her expectation staff would not touch food directly after direct contact with resident meal cards. Although requested, the facility did not provide any policy related to appropriate glove use in relation to food preparation at the time of the survey.	F 812	During observation on 10/22/18 at 5:24 pm and again at 5:33 pm, nursing assistant NA-A was noted to be scratching her head, leaning her face on her hand and rubbing her ear. NA-A did not sanitize her hands appropriately before continuing to feed resident R18. During observation on 10/22/18 at 5:35 pm, LPN-C was observed in the dining room serving meals to residents. LPN-C was observed to use her two-way radio and then return it to her pocket. LPN-C continued to serve meals and set up flatware without changing her gloves or sanitizing her hands. During observation on 10/22/18 at 5:41 pm, RN-B was observed assisting resident R7 to eat. RN-B was observed scratching and rubbing her neck, then proceeding to hold resident R7's drinking glass for the resident without performing hand hygiene. To prevent further recurrences of this deficiency, the food service director and infection control preventionist reviewed policies regarding food service, handwashing and use of infection control supplies, including gloves and hand sanitizer. The Serving Food Policy was revised slightly to ensure that all departmental staff that assist at serving meals are included in the policy. The Infection Control Preventionist revised the Use of Infection Control Supplies Policy so that the section on glove use and hand sanitizer includes the serving of food. Handwashing policies of both departments were also reviewed. The	

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F 812	Continued From page 14	F 812	Infection Control Preventionist will be conducting random audits weekly in the dining rooms and on the floor to ensure staff is observing the correct infection control practices while serving food and completing other tasks. She will also be doing education with staff as necessary regarding these policies. The food service director has revised her food serving policy and reviewed this with her staff. She will also be conducting random audits of the dietary staff in the kitchen and dining room to ensure they are using the correct food service and infection control practices during meal preparation and service. Further education will be conducted as necessary. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: Food Service Director, Infection Control Preventionist	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey the Parkview Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

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

Electronically Signed | 11/16/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	**102 COUNTY STATE AID HIGHWAY 9** **BELVIEW, MN 56214**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Parkview Home was constructed as follows: The original building was built in 1965, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The first addition was built in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The second addition was built in 1990, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The most recent addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. The facility has an automatic fire alarm system with smoke detection at all smoke barrier doors	K 000		

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	245475	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2018**

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K 000	Continued From page 2 and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 28 at time of the survey.	K 000		
K 200 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to comply with LSC 19.2 Failure could result in fire doors not operating. This deficient practice could affect the safety of all (28) the residents, staff and visitors within the Facility.	K 200	Facility does not have a current fire/smoke door inspection process. ACTION: The Facility Maintenance Director has completed the 2018 fire and smoke door inspection for all required doors. The inspection form will be kept in a fire and smoke door binder located in the maintenance room. Fire and smoke door inspections will be completed	12/3/18

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K 200	Continued From page 3 Findings Include: On facility tour between 09:00 AM and 012:00 PM on 10/23/2018, observation and documentation reviewed revealed the following: The Facility does not have a current fire/smoke door inspection. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 200	annually and filed in said binder. Two years of inspections will be kept in the binder and previous years will be kept on file for reference. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: Facility Maintenance Director	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. This deficient practice could effect 28 of the 28 Residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345	During facility tour on 10/23/18, and during documentation review, it was revealed that the Fire Alarm DACT system was not tested during the months of December 2017, February 2018, March 2018. ACTION: The Facility Maintenance Director will test the DACT system monthly with a minimum of 12 tests annually. The Maintenance Director will conduct the test along with the monthly fire drill and quarterly sprinkler flow test.	12/3/18

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	245475	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2018**

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K 345	Continued From page 4 acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 10/23/2018, during documentation review, it was revealed that the Fire Alarm DACT system was not tested during the months of December, 2017; February, 2018; and March, 2018. This deficient practice was verified by the Facility Maintenance Director.	K 345	Results and confirmation from the monitoring company (DACT) will be documented on the fire drill and quarterly sprinkler worksheet. All documentation will be kept in the life safety binder in the maintenance room. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: Facility Maintenance Director	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		12/3/18

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PARKVIEW HOME	**102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214**

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K 353	Continued From page 5 by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 28 out of 28 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 10/23/2018, during documentation review, documentation could not be provided to show that a quarterly fire sprinkler inspection occurred during the past year. This deficient practice was verified by the Facility Maintenence Director.	K 353	Based on observation and review, the facility failed to maintain the automatic sprinkler system in accordance with 9.7.5., 9.7.7., 9.7.8., and NFPA 25. This deficient practice could affect 28 out of 28 residents. ACTION: The Facility Maintenance Director will conduct quarterly testing of the automatic sprinkler and standpipe system in accordance with NFPA 25. Documentation will be recorded on the quarterly sprinkler inspection and flow test form. The form will include the name of inspector; time; date; date of last inspection; pressure before, during and after the test; location; water system supply source; confirmation from monitoring company (DACT) and any problems with inspection or flow test. All quarterly sprinkler and flow test documentation will be kept in the life safety binder in the maintenance room. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: Facility Maintenance Director	

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K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to conduct Fire Drills in accordnance with 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. This deficient practice could affect 28 of 28 residents. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. FINDINGS INCLUDE:	K 712	Facility failed to conduct fire drills in accordance with 18.7.1.4. through 12.7.1.7., 19.7.1.4. through 19.7.1.4. This deficient practice could affect 28 out of 28 residents. On facility tour on 10/23/18, documentation review revealed that fire drills were not conducted during the 2nd quarter on the 2nd shift and during the 4th quarter on the 2nd shift. ACTION: The Facility Maintenance Director will conduct monthly fire drills, so that each shift (Days, PMs, and nights) will each have four drills annually. The director will conduct a simulated fire situation and monitor staff performance. After the drill is completed, staff will sign a participation form and the director will critique the drill procedures and re-educate staff on areas of improvement needed. Drills between 9 pm and 6 am will be a silent alarm and will use a code red announcement. All drills will be	12/3/18

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K 712	Continued From page 7 On facility tour between 9:00 AM and 12:00 PM on 10/23/18, documentation review revealed revealed that fire drills were not conducted during the 2nd quarter on the 2nd shift and the during the 4th quarter on the 2nd shift. This deficient practice was verified by the Facility Maintenance Director.	K 712	conducted using the fire alarm system (DACT) other than drills between 9 pm and 6 am. These drills will be silent and then the (DACT) system will be tested the next day or day of after 6 am. All documentation will done on the fire drill form, including (DACT) confirmation and will be kept in the life safety binder in the maintenance room. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: Facility Maintenance Director	
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K 914		12/3/18

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K 914	Continued From page 8 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99). This deficient practice could effect 28 out of 28 Residents. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 1-/232018, during documentation review and interview, documentation could not be located to show that the non-hospital rated electrical respectables within the resident rooms are tested at intervals not exceeding 12 months. This deficient practice was verified by the Facility Maintenance Director.	K 914	Upon documentation review and interview, documentation could not be located to show that the non-hospital rated electrical receptacles within the resident rooms are tested at intervals not exceeding 12 months. This deficient practice could affect 28 out of 28 residents. ACTION: The Facility Maintenance Director will provide maintenance and testing of hospital-grade receptacles at resident bed locations, after initial installation, replacement or servicing. Additional testing will be done at intervals defined by performance data. Receptacles not listed as hospital grade, will be tested at intervals not exceeding 12 months. See NFPA 101. Records of test and associated repairs or modifications, containing dates, room or area tested and the results will be located in an outlet receptacle binder located in the maintenance room. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: Facility Maintenance Director	

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K 918	Continued From page 9	K 918		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918		12/3/18

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K 918	Continued From page 10 Based on documentation review and interview, the Facility failed to provide complete written records of generator maintenance and testing. This deficient practice could affect 28 of 28 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918	On facility tour on 10/23/18 during documentation review and interview, the facility failed to provide complete written records of generator maintenance and testing. This deficient practice could effect 28 of 28 residents. ACTION: The annual generator service and inspection will be completed annually by a qualified technician from Interstate Power of Sioux Falls, SD. They will be conducting an annual generator service to include full service and inspection of the generator motor and electrical system. They will inspect and test the generator automatic transfer switch (ATS). Annual generator inspection documentation will be kept along with the monthly test and weekly inspection in the life safety binder in the maintenance room. COMPLETION DATE: 12/3/18 RESPONSIBLE PERSON: Facility Maintenance Director	

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K 918	Continued From page 11 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 10/23/2018, during documentation review, it was revealed that documentation could not be located to show that annual maintenance had occurred on the emergency generator. This deficient practice was verified by the Facility Maintenance Director.	K 918		