Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 31, 2026

Administrator
PARKVIEW CARE CENTER
55 TENTH STREET SOUTHEAST
WELLS, MN 56097

RE: CCN: 245436
Cycle Start Date: June 3, 2026

Dear Administrator:

On July 29, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 - HVAC at the time of the June 4, 2026, standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	55 TENTH STREET SOUTHEAST , WELLS, Minnesota, 56097

(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
E0000	Initial Comments On 6/2/26 to 6/4/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		07/02/2026
F0000	INITIAL COMMENTS On 6/2/26 to 6/4/26, a standard recertification survey (S5436038) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54362649C (iQIES #3027211) with deficiency cited at (F825). 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 substantial compliance with the regulations has been attained.	F0000		07/02/2026
F0825 SS = E	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services.	F0825	Thank you for the opportunity to clarify our submitted Plan of Correction. The facility completed its resident audit on July 1, 2026. At the time the audit was conducted, the facility census was 17 residents; therefore, all 17 current residents were reviewed. We apologize for any confusion regarding the number of residents	07/07/2026

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 reverse for further 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.

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

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F0825 SS = E	Continued from page 1 If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide physical therapy and occupational therapy as ordered for 5 of 5 residents (R2, R8, R13, R25, R26) reviewed for rehabilitation and restorative services. Findings include: R2's face sheet printed 6/4/26, indicated diagnoses of acute heart failure, chronic pain syndrome, and kidney disease. R2's care plan dated 2/17/26, indicated acute and chronic pain related to lower leg ulcers and chronic pain syndrome with interventions of non-medicated pain relief measures such as massage, physical therapy, and strengthening and stretching exercises. R2's physician's orders dated 5/29/26, indicated occupational and physical therapy eval and treat. R2's quarterly Minimum Data Set (MDS) assessment dated 5/14/26, indicated intact cognition, rejection of care one to three days, use of wheelchair, dependent on staff for toileting hygiene, lower body dressing, and personal hygiene. R8's face sheet printed 6/4/26, indicated diagnoses of dysphagia (difficulty swallowing), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right side impairments due to stroke). R8's care plan dated 4/14/26, indicated activities of	F0825	Continued from page 1 reviewed. The facility has secured a contract with Pro Rehab to provide on-site Physical Therapy, Occupational Therapy, and Speech Therapy services. The agreement became effective June 18, 2026, and Pro Rehab began providing on-site therapy services on June 29, 2026. Therapy evaluations and treatments are now available on-site in accordance with physician orders and resident needs. The interdisciplinary team reviewed all 17 residents residing in the facility on July 1, 2026. The review included residents currently receiving therapy services, residents with physician orders for therapy services, residents identified with limited range of motion or impaired mobility, and residents whose diagnoses or functional status indicated they may benefit from therapy services. Resident care plans, physician orders, therapy documentation, and functional assessments were reviewed to ensure therapy needs were identified and addressed. Referrals for therapy evaluations were initiated and care plans updated as appropriate. Education was provided to licensed nurses, certified nursing assistants, Social Services, Activities, Dietary, and members of the interdisciplinary team regarding the facility's process for identifying residents who may require therapy services, recognizing changes in resident function that may warrant a therapy referral, obtaining timely physician orders for therapy evaluations, communicating therapy needs with the contracted therapy provider, documenting therapy referrals and physician orders, and reviewing resident care plans to ensure therapy needs are addressed. The Director of Nursing or designee will complete weekly audits for four weeks, followed by monthly audits until the next quarterly QAPI meeting. Audits will verify that physician orders for therapy are obtained timely, ordered therapy services are being provided, residents with limited range of motion or functional decline are evaluated for therapy when indicated, resident care plans accurately reflect therapy services when applicable, and corrective action and additional staff education are provided immediately if concerns are identified. Audit findings will be reviewed through the facility's QAPI process to ensure ongoing compliance.	07/07/2026

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F0825 SS = E	Continued from page 2 daily living (ADL) assistance needed for transfers due to recent stroke, with intervention on one assist for transfers and occupational and physical therapy to eval and treat. R8's physician's orders dated 4/14/26, indicated occupational, physical, and speech therapy eval and treat. R8's admission MDS assessment dated 5/6/26, indicated moderately impaired cognition, no behaviors, use of wheelchair, dependent on staff for bathing, toileting hygiene, and dressing. R13's face sheet printed 6/4/26, indicated diagnoses of end stage kidney disease, heart failure, and diabetes mellitus. R13's care plan dated 9/26/25, indicated desire to go home after meeting goals in therapy with interventions of evaluating and discussing the prognosis for independent or assisted living. R13's physician's orders dated 5/29/26, indicated physical and occupational therapy eval and treat. R13's admission MDS assessment dated 6/2/26, indicated intact cognition, no behaviors or rejection of care, use of wheelchair, dependent for transfers and dressing, set up for personal hygiene. R25's face sheet printed 6/4/26, indicated diagnoses of surgical aftercare following skin surgery, diabetes mellitus, kidney disease, and obesity. R25's care plan dated 5/27/26, indicated desire to return home following short term rehabilitation with interventions of evaluating motivation to return to community with assistance on home care. R25's physician's orders dated 5/26/26, indicated occupational and physical therapy eval and treat. R25's admission MDS was not yet completed. R26's face sheet received on 6/4/26, included diagnoses of polyarthritis (arthritis affecting five or more joints at the same time), chronic obstructive pulmonary disease, or COPD (lung disease that restricts airflow making it hard to breathe), obesity and history of falling. R26's admission MDS assessment dated 5/22/26, indicated intact cognition, clear speech, could understand and be understood. R26 required	F0825		07/07/2026

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F0825 SS = E	Continued from page 3 supervision or partial assistance with activities of daily living (ADLs), required substantial assistance moving from chair to bed, was dependent upon staff for dressing, and did not walk distances due to medical condition or safety concerns. R26 used a wheelchair for mobility. R26's care area assessment for ADLs indicated R26 was admitted for short term rehabilitation following hospitalization. The goal was to improve functional abilities and return to prior living situation. R26's admission orders from the hospital dated 5/20/26, included occupational and physical therapy evaluation and treatment. Meaning occupational and physical therapy professionals would meet with R26 and evaluate therapy needs and establish a treatment plan. R26's care plan dated 5/20/26, indicated an ADL self-care deficit related to weakness/illness and chronic pain related to osteoarthritis of both knees causing joint pain which could lead to impaired physical mobility and inability to care for herself. R26 was considered a moderate risk of falling due to deconditioning, gait and balance problems. During interview on 6/2/26 and 2:39 p.m., R2 stated he had recently been hospitalized and returned to the facility. R2 stated he was supposed to be doing therapy, but there was no therapy available at the facility. R2 further stated he chose to return to the facility because he had been living there previously and didn't want to go anywhere else. R2 stated he was fine with waiting for the facility to get new therapy services. During interview on 6/2/26 at 3:00 p.m., R8 stated he was at the facility for therapy and planned to go home when done. R8 stated he was informed that therapy was not available anymore and wanted to go to a facility in a different town. R8 stated the facility was helping him get that arranged. During interview on 6/2/26 at 4:10 p.m., R13 stated she had recently been readmitted from the hospital and was supposed to be getting therapy services. R13 stated the facility told her they didn't have therapy right now, but she wanted to remain in the facility and wait until they hired new therapists. During interview on 6/3/26 at 10:40 a.m., R25 stated he was supposed to be doing therapy at the facility but didn't think he really needed it. R25 further stated he wanted to be in the facility and didn't want to go anywhere else. R25 stated he was going	F0825		07/07/2026

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F0825 SS = E	Continued from page 4 to remain at the facility until they got new therapy services. During an interview on 6/2/26 at 3:34 p.m., R26 stated she was there for short term rehabilitation but didn't get walked in the hall, adding she had arthritis in both knees and needed to get stronger so she could go home. During record review, a handwritten progress note dated 5/29/26 at 4:00 p.m., written by the director of nursing (DON) indicated R26 had been informed of therapy services being discontinued at the facility. The note indicated the DON had met with R26 and explained options including moving to another facility to receive therapy services. The note indicated R26 had been concerned she was getting kicked out of the facility and was informed she could stay if she desired, but if she wanted to continue therapy services, she could transfer to a facility in another town. R26 stated she wanted to think about it and would let the DON know. During record review, R26 had received a Notice of Medicare Non-Coverage form indicating her therapy services were ending on 5/31/26. The form had been signed by R26 on 5/29/26. The form indicated R26's Medicare provider and/or health plan had determined Medicare would probably not pay for current skilled services after the effective date of 5/31/26, and that R26 may have to pay for any services received after that date. During record review, a progress note dated 6/3/26 at 1:38 p.m., written by social service designee (SSD)-A indicated there had been a meeting with R26, family member (FM)-A, county case worker (CW)-G, the DON and SSD-A. CW-A had explained R26's options and if she were to stay long term, what her finances would look like. R26 agreed to continue therapy services at the facility and once graduated, would potentially stay long term. During a telephone interview on 6/3/26 at 9:58 a.m., medical director (MD)-D, stated he learned the facility no longer had therapy services (physical, occupational and speech therapy) when doing rounds at the facility on 5/28/26. MD-D stated he had not been brought into discussions about the reason therapy services had been discontinued nor the plan going forward to provide services to residents. MD-D stated it was a significant issue, and residents and families needed to be informed of alternate options for receiving therapy services. MD-D stated there was concern for residents	F0825		07/07/2026

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F0825 SS = E	Continued from page 5 declining in strength and potentially developing pneumonia or pressure sores. MD-D stated he would have expected leadership staff to have informed him of the changes in therapy services as soon as they became aware in order for him to lend guidance and be part of developing alternate plans. During an interview on 6/3/26 at 10:33 a.m., the director of nursing (DON) stated she learned about therapy services discontinuing services via an email on 5/28/26. Prior to that, the DON stated in an email dated 5/20/26, therapy services had informed the facility they would no longer be providing in-person therapy and would be switching to services via telehealth. The DON stated this came as a surprise as there had been no prior communication about changing or discontinuing services. Then in an email on 5/28/26, therapy services indicated everything was on hold, including services via telehealth. The DON stated the administrator asked her to reach out to MD-D to ask about sharing therapy services with the hospital he was affiliated with. In the meantime, the DON stated she and social worker designee (SSD)-A had started talking to residents and families who were affected by therapy services, offering assistance to receive services off-campus or moving to a different facility. During a telephone interview on 6/3/26 at 11:44 a.m., chief executive officer (CEO)-E of corporate services stated he became aware therapy services had discontinued services on 5/28/26, due to a significant outstanding balance owed to therapy services. CEO-E stated it had taken about seven to nine months to accumulate the bill and during the first four or five months had been working with therapy services about a payment plan. Time went by without communication from therapy services, and then recently (last week), the two parties had worked out a payment plan and had set up automatic bank withdrawal. Following that, therapy services discontinued all services. CEO-E stated decisions about which bills to pay came down to residents' safety and care was #1, which included electricity, water, gas. Paying food vendors was #2, and payroll was #3. "Beyond that, we pay what we can to outstanding vendors with cash on hand." During an interview on 6/3/26 at 12:03 p.m., the regional director of skilled nursing facility operations (RD)-F stated she first learned of changes to therapy services when on 5/20/26, someone at a sister facility had been informed therapy services would be changed to telehealth visits. From 5/21/26 to 5/29/26, RD-F stated she had attempted to reach out to therapy services via phone, email and text but	F0825		07/07/2026

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F0825 SS = E	Continued from page 6 received no response. RD-F stated therapy services pulled their services without providing notice. RD-F stated she had been aware the facility owed therapy services a significant amount of money and knew CEO-E had been trying to work something out. During an interview on 6/3/26 at 1:02 p.m., the administrator stated she learned therapy services were being discontinued via an email on 5/28/26. The administer had been aware therapy services initially moved to telehealth therapy from in-person visits before discontinuing services altogether. The administrator had been aware a payment plan with therapy services had been set up. The administrator stated right away, the DON started looking at the possibility of utilizing therapy services at a nearby hospital but nothing had been determined. During an interview on 6/4/26 at 8:40 a.m., the DON stated therapy services had last been in the facility providing services on 5/22/26, and it was business as usual. The DON stated therapy services, either occupational therapy or physical therapy, were in the building Monday through Friday. An email from therapy services dated 5/20/26, indicated they would be conducting therapy visits via telehealth, then on 5/28/26, the facility received an email that telehealth was on hold until further notice. The DON stated she had informed MD-D about this change on 5/28/26, when doing rounds. The DON admitted she had not asked MD-D to see and/or talk to affected residents and their families, or to review therapy orders of affected residents to determine an interim course of action. The DON stated she had not thought to do that and acknowledged the potential risk for residents to decline without a plan for continued therapy. During an interview on 6/4/26 at 8:54 a.m., the assistant administrator stated she became aware of therapy services discontinuing services when the State survey team arrived on site on 6/2/26. She had been aware therapy services initially moved to telehealth therapy from in-person visits. The assistant administrator stated facility leadership discussed therapy services at their daily IDT (interdisciplinary team) meetings on 5/21/26 and 5/26/26. They had discussed details of the situation, why it was happening, a way to expedite payment to therapy services and the role of nurses to facilitate the process of therapy via telehealth until things could be sorted out. The assistant administrator acknowledged leadership did not think to bring MD-D into the discussion to inform him of what was happening and why, and how to determine a course of action to prevent residents from declining without	F0825		07/07/2026

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F0825 SS = E	Continued from page 7 therapy services. During a telephone interview on 6/4/26 at 11:47 a.m., RD-F stated she had met with a local therapy group who had agreed to provide therapy services, and would be signing a contract on 6/4/26, or on 6/5/26, and services would start sometime the following week. During record review, an email dated 5/20/26 at 8:58 p.m., from therapy services indicated due to ongoing lack of payment, therapy services would be implementing a reduction in services effective 5/25/26. All therapy services would be delivered via telehealth, with sessions being facilitated by a facility employee. Treatments would be 15 minutes in length and require a designated facility employee present. Services would be limited to specific days of the week and times. Services would be limited to skilled residents only. When current long-term care clients came off therapy, they would not be adding new part B therapy clients. Therapy services had enjoyed providing care to the facility; however, this was how therapy services must move forward due to payment issues while still trying to meet clients' immediate skilled needs. During record review, an email dated 5/27/26, at 6:04 p.m., from therapy services indicated no telehealth therapy would be provided tomorrow (5/28/26), and therapy services would not be rescheduling appointments. Someone would get back to the facility about on-going plans. According to the DON, that was the last communication received from therapy services. Review of agreement between facility and therapy services entered into on 5/11/23, and signed by both parties on 5/18/23, indicated therapy services (known as Contractor) may terminate the agreement upon ten (10) days' written notice to the facility (known as HCP or health care provider), if HCP failed to pay Contractor any fee, expense or other sum of money when due; provided, however, if HCP has defaulted three (3) times in the performance of its payment obligations during any twelve (12) month period, the Contractor may provide notice of termination, effect immediately, on the first day after the date of such written notice is given to HCP, and an opportunity to cure shall not be granted unless explicitly permitted in writing by the Contractor. Facility assessment dated 5/2026, indicated the facility offered both inpatient and outpatient therapy and rehabilitation services. Therapy services offered a wide variety of therapy services for residents,	F0825		07/07/2026

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F0825 SS = E	Continued from page 8 including physical therapy, occupational therapy and speech therapy. Therapy services were provided under contract and included licensed physical and occupational therapists and speech-language pathologists. Facility Therapy Evaluation policy dated 2025, indicated the licensed therapist would perform an initial resident evaluation upon physician referral and any reevaluation where indicated. The rehabilitation department would be notified when a physician order was written for therapy evaluation and treatment. The licensed therapist would perform a chart review and initiate the evaluation.	F0825		07/07/2026

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June 26, 2026

Administrator
PARKVIEW CARE CENTER
55 TENTH STREET SOUTHEAST
WELLS, MN 56097

RE: CCN:245436
Cycle Start Date: June 3, 2026

Dear Administrator:

On June 3, 2026, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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 September 3, 2026 (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 December 3, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	55 TENTH STREET SOUTHEAST , WELLS, Minnesota, 56097

(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
E0000	Initial Comments On 6/2/26 to 6/4/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		07/02/2026
F0000	INITIAL COMMENTS On 6/2/26 to 6/4/26, a standard recertification survey (S5436038) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54362649C (iQIES #3027211) with deficiency cited at (F825). 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 substantial compliance with the regulations has been attained.	F0000		07/02/2026
F0825 SS = E	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services.	F0825	Thank you for the opportunity to clarify our submitted Plan of Correction. The facility completed its resident audit on July 1, 2026. At the time the audit was conducted, the facility census was 17 residents; therefore, all 17 current residents were reviewed. We apologize for any confusion regarding the number of residents	07/07/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0825 SS = E	Continued from page 1 If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide physical therapy and occupational therapy as ordered for 5 of 5 residents (R2, R8, R13, R25, R26) reviewed for rehabilitation and restorative services. Findings include: R2's face sheet printed 6/4/26, indicated diagnoses of acute heart failure, chronic pain syndrome, and kidney disease. R2's care plan dated 2/17/26, indicated acute and chronic pain related to lower leg ulcers and chronic pain syndrome with interventions of non-medicated pain relief measures such as massage, physical therapy, and strengthening and stretching exercises. R2's physician's orders dated 5/29/26, indicated occupational and physical therapy eval and treat. R2's quarterly Minimum Data Set (MDS) assessment dated 5/14/26, indicated intact cognition, rejection of care one to three days, use of wheelchair, dependent on staff for toileting hygiene, lower body dressing, and personal hygiene. R8's face sheet printed 6/4/26, indicated diagnoses of dysphagia (difficulty swallowing), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right side impairments due to stroke). R8's care plan dated 4/14/26, indicated activities of	F0825	Continued from page 1 reviewed. The facility has secured a contract with Pro Rehab to provide on-site Physical Therapy, Occupational Therapy, and Speech Therapy services. The agreement became effective June 18, 2026, and Pro Rehab began providing on-site therapy services on June 29, 2026. Therapy evaluations and treatments are now available on-site in accordance with physician orders and resident needs. The interdisciplinary team reviewed all 17 residents residing in the facility on July 1, 2026. The review included residents currently receiving therapy services, residents with physician orders for therapy services, residents identified with limited range of motion or impaired mobility, and residents whose diagnoses or functional status indicated they may benefit from therapy services. Resident care plans, physician orders, therapy documentation, and functional assessments were reviewed to ensure therapy needs were identified and addressed. Referrals for therapy evaluations were initiated and care plans updated as appropriate. Education was provided to licensed nurses, certified nursing assistants, Social Services, Activities, Dietary, and members of the interdisciplinary team regarding the facility's process for identifying residents who may require therapy services, recognizing changes in resident function that may warrant a therapy referral, obtaining timely physician orders for therapy evaluations, communicating therapy needs with the contracted therapy provider, documenting therapy referrals and physician orders, and reviewing resident care plans to ensure therapy needs are addressed. The Director of Nursing or designee will complete weekly audits for four weeks, followed by monthly audits until the next quarterly QAPI meeting. Audits will verify that physician orders for therapy are obtained timely, ordered therapy services are being provided, residents with limited range of motion or functional decline are evaluated for therapy when indicated, resident care plans accurately reflect therapy services when applicable, and corrective action and additional staff education are provided immediately if concerns are identified. Audit findings will be reviewed through the facility's QAPI process to ensure ongoing compliance.	07/07/2026

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F0825 SS = E	Continued from page 2 daily living (ADL) assistance needed for transfers due to recent stroke, with intervention on one assist for transfers and occupational and physical therapy to eval and treat. R8's physician's orders dated 4/14/26, indicated occupational, physical, and speech therapy eval and treat. R8's admission MDS assessment dated 5/6/26, indicated moderately impaired cognition, no behaviors, use of wheelchair, dependent on staff for bathing, toileting hygiene, and dressing. R13's face sheet printed 6/4/26, indicated diagnoses of end stage kidney disease, heart failure, and diabetes mellitus. R13's care plan dated 9/26/25, indicated desire to go home after meeting goals in therapy with interventions of evaluating and discussing the prognosis for independent or assisted living. R13's physician's orders dated 5/29/26, indicated physical and occupational therapy eval and treat. R13's admission MDS assessment dated 6/2/26, indicated intact cognition, no behaviors or rejection of care, use of wheelchair, dependent for transfers and dressing, set up for personal hygiene. R25's face sheet printed 6/4/26, indicated diagnoses of surgical aftercare following skin surgery, diabetes mellitus, kidney disease, and obesity. R25's care plan dated 5/27/26, indicated desire to return home following short term rehabilitation with interventions of evaluating motivation to return to community with assistance on home care. R25's physician's orders dated 5/26/26, indicated occupational and physical therapy eval and treat. R25's admission MDS was not yet completed. R26's face sheet received on 6/4/26, included diagnoses of polyarthritis (arthritis affecting five or more joints at the same time), chronic obstructive pulmonary disease, or COPD (lung disease that restricts airflow making it hard to breathe), obesity and history of falling. R26's admission MDS assessment dated 5/22/26, indicated intact cognition, clear speech, could understand and be understood. R26 required	F0825		07/07/2026

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F0825 SS = E	Continued from page 3 supervision or partial assistance with activities of daily living (ADLs), required substantial assistance moving from chair to bed, was dependent upon staff for dressing, and did not walk distances due to medical condition or safety concerns. R26 used a wheelchair for mobility. R26's care area assessment for ADLs indicated R26 was admitted for short term rehabilitation following hospitalization. The goal was to improve functional abilities and return to prior living situation. R26's admission orders from the hospital dated 5/20/26, included occupational and physical therapy evaluation and treatment. Meaning occupational and physical therapy professionals would meet with R26 and evaluate therapy needs and establish a treatment plan. R26's care plan dated 5/20/26, indicated an ADL self-care deficit related to weakness/illness and chronic pain related to osteoarthritis of both knees causing joint pain which could lead to impaired physical mobility and inability to care for herself. R26 was considered a moderate risk of falling due to deconditioning, gait and balance problems. During interview on 6/2/26 and 2:39 p.m., R2 stated he had recently been hospitalized and returned to the facility. R2 stated he was supposed to be doing therapy, but there was no therapy available at the facility. R2 further stated he chose to return to the facility because he had been living there previously and didn't want to go anywhere else. R2 stated he was fine with waiting for the facility to get new therapy services. During interview on 6/2/26 at 3:00 p.m., R8 stated he was at the facility for therapy and planned to go home when done. R8 stated he was informed that therapy was not available anymore and wanted to go to a facility in a different town. R8 stated the facility was helping him get that arranged. During interview on 6/2/26 at 4:10 p.m., R13 stated she had recently been readmitted from the hospital and was supposed to be getting therapy services. R13 stated the facility told her they didn't have therapy right now, but she wanted to remain in the facility and wait until they hired new therapists. During interview on 6/3/26 at 10:40 a.m., R25 stated he was supposed to be doing therapy at the facility but didn't think he really needed it. R25 further stated he wanted to be in the facility and didn't want to go anywhere else. R25 stated he was going	F0825		07/07/2026

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F0825 SS = E	Continued from page 4 to remain at the facility until they got new therapy services. During an interview on 6/2/26 at 3:34 p.m., R26 stated she was there for short term rehabilitation but didn't get walked in the hall, adding she had arthritis in both knees and needed to get stronger so she could go home. During record review, a handwritten progress note dated 5/29/26 at 4:00 p.m., written by the director of nursing (DON) indicated R26 had been informed of therapy services being discontinued at the facility. The note indicated the DON had met with R26 and explained options including moving to another facility to receive therapy services. The note indicated R26 had been concerned she was getting kicked out of the facility and was informed she could stay if she desired, but if she wanted to continue therapy services, she could transfer to a facility in another town. R26 stated she wanted to think about it and would let the DON know. During record review, R26 had received a Notice of Medicare Non-Coverage form indicating her therapy services were ending on 5/31/26. The form had been signed by R26 on 5/29/26. The form indicated R26's Medicare provider and/or health plan had determined Medicare would probably not pay for current skilled services after the effective date of 5/31/26, and that R26 may have to pay for any services received after that date. During record review, a progress note dated 6/3/26 at 1:38 p.m., written by social service designee (SSD)-A indicated there had been a meeting with R26, family member (FM)-A, county case worker (CW)-G, the DON and SSD-A. CW-A had explained R26's options and if she were to stay long term, what her finances would look like. R26 agreed to continue therapy services at the facility and once graduated, would potentially stay long term. During a telephone interview on 6/3/26 at 9:58 a.m., medical director (MD)-D, stated he learned the facility no longer had therapy services (physical, occupational and speech therapy) when doing rounds at the facility on 5/28/26. MD-D stated he had not been brought into discussions about the reason therapy services had been discontinued nor the plan going forward to provide services to residents. MD-D stated it was a significant issue, and residents and families needed to be informed of alternate options for receiving therapy services. MD-D stated there was concern for residents	F0825		07/07/2026

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F0825 SS = E	Continued from page 5 declining in strength and potentially developing pneumonia or pressure sores. MD-D stated he would have expected leadership staff to have informed him of the changes in therapy services as soon as they became aware in order for him to lend guidance and be part of developing alternate plans. During an interview on 6/3/26 at 10:33 a.m., the director of nursing (DON) stated she learned about therapy services discontinuing services via an email on 5/28/26. Prior to that, the DON stated in an email dated 5/20/26, therapy services had informed the facility they would no longer be providing in-person therapy and would be switching to services via telehealth. The DON stated this came as a surprise as there had been no prior communication about changing or discontinuing services. Then in an email on 5/28/26, therapy services indicated everything was on hold, including services via telehealth. The DON stated the administrator asked her to reach out to MD-D to ask about sharing therapy services with the hospital he was affiliated with. In the meantime, the DON stated she and social worker designee (SSD)-A had started talking to residents and families who were affected by therapy services, offering assistance to receive services off-campus or moving to a different facility. During a telephone interview on 6/3/26 at 11:44 a.m., chief executive officer (CEO)-E of corporate services stated he became aware therapy services had discontinued services on 5/28/26, due to a significant outstanding balance owed to therapy services. CEO-E stated it had taken about seven to nine months to accumulate the bill and during the first four or five months had been working with therapy services about a payment plan. Time went by without communication from therapy services, and then recently (last week), the two parties had worked out a payment plan and had set up automatic bank withdrawal. Following that, therapy services discontinued all services. CEO-E stated decisions about which bills to pay came down to residents' safety and care was #1, which included electricity, water, gas. Paying food vendors was #2, and payroll was #3. "Beyond that, we pay what we can to outstanding vendors with cash on hand." During an interview on 6/3/26 at 12:03 p.m., the regional director of skilled nursing facility operations (RD)-F stated she first learned of changes to therapy services when on 5/20/26, someone at a sister facility had been informed therapy services would be changed to telehealth visits. From 5/21/26 to 5/29/26, RD-F stated she had attempted to reach out to therapy services via phone, email and text but	F0825		07/07/2026

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F0825 SS = E	Continued from page 6 received no response. RD-F stated therapy services pulled their services without providing notice. RD-F stated she had been aware the facility owed therapy services a significant amount of money and knew CEO-E had been trying to work something out. During an interview on 6/3/26 at 1:02 p.m., the administrator stated she learned therapy services were being discontinued via an email on 5/28/26. The administer had been aware therapy services initially moved to telehealth therapy from in-person visits before discontinuing services altogether. The administrator had been aware a payment plan with therapy services had been set up. The administrator stated right away, the DON started looking at the possibility of utilizing therapy services at a nearby hospital but nothing had been determined. During an interview on 6/4/26 at 8:40 a.m., the DON stated therapy services had last been in the facility providing services on 5/22/26, and it was business as usual. The DON stated therapy services, either occupational therapy or physical therapy, were in the building Monday through Friday. An email from therapy services dated 5/20/26, indicated they would be conducting therapy visits via telehealth, then on 5/28/26, the facility received an email that telehealth was on hold until further notice. The DON stated she had informed MD-D about this change on 5/28/26, when doing rounds. The DON admitted she had not asked MD-D to see and/or talk to affected residents and their families, or to review therapy orders of affected residents to determine an interim course of action. The DON stated she had not thought to do that and acknowledged the potential risk for residents to decline without a plan for continued therapy. During an interview on 6/4/26 at 8:54 a.m., the assistant administrator stated she became aware of therapy services discontinuing services when the State survey team arrived on site on 6/2/26. She had been aware therapy services initially moved to telehealth therapy from in-person visits. The assistant administrator stated facility leadership discussed therapy services at their daily IDT (interdisciplinary team) meetings on 5/21/26 and 5/26/26. They had discussed details of the situation, why it was happening, a way to expedite payment to therapy services and the role of nurses to facilitate the process of therapy via telehealth until things could be sorted out. The assistant administrator acknowledged leadership did not think to bring MD-D into the discussion to inform him of what was happening and why, and how to determine a course of action to prevent residents from declining without	F0825		07/07/2026

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F0825 SS = E	Continued from page 7 therapy services. During a telephone interview on 6/4/26 at 11:47 a.m., RD-F stated she had met with a local therapy group who had agreed to provide therapy services, and would be signing a contract on 6/4/26, or on 6/5/26, and services would start sometime the following week. During record review, an email dated 5/20/26 at 8:58 p.m., from therapy services indicated due to ongoing lack of payment, therapy services would be implementing a reduction in services effective 5/25/26. All therapy services would be delivered via telehealth, with sessions being facilitated by a facility employee. Treatments would be 15 minutes in length and require a designated facility employee present. Services would be limited to specific days of the week and times. Services would be limited to skilled residents only. When current long-term care clients came off therapy, they would not be adding new part B therapy clients. Therapy services had enjoyed providing care to the facility; however, this was how therapy services must move forward due to payment issues while still trying to meet clients' immediate skilled needs. During record review, an email dated 5/27/26, at 6:04 p.m., from therapy services indicated no telehealth therapy would be provided tomorrow (5/28/26), and therapy services would not be rescheduling appointments. Someone would get back to the facility about on-going plans. According to the DON, that was the last communication received from therapy services. Review of agreement between facility and therapy services entered into on 5/11/23, and signed by both parties on 5/18/23, indicated therapy services (known as Contractor) may terminate the agreement upon ten (10) days' written notice to the facility (known as HCP or health care provider), if HCP failed to pay Contractor any fee, expense or other sum of money when due; provided, however, if HCP has defaulted three (3) times in the performance of its payment obligations during any twelve (12) month period, the Contractor may provide notice of termination, effect immediately, on the first day after the date of such written notice is given to HCP, and an opportunity to cure shall not be granted unless explicitly permitted in writing by the Contractor. Facility assessment dated 5/2026, indicated the facility offered both inpatient and outpatient therapy and rehabilitation services. Therapy services offered a wide variety of therapy services for residents,	F0825		07/07/2026

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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
F0825 SS = E	Continued from page 8 including physical therapy, occupational therapy and speech therapy. Therapy services were provided under contract and included licensed physical and occupational therapists and speech-language pathologists. Facility Therapy Evaluation policy dated 2025, indicated the licensed therapist would perform an initial resident evaluation upon physician referral and any reevaluation where indicated. The rehabilitation department would be notified when a physician order was written for therapy evaluation and treatment. The licensed therapist would perform a chart review and initiate the evaluation.	F0825		07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING **01 - MAIN BUILD...** B. WING	**06/03/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/03/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Parkview Care Center 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		07/06/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/03/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. PARKVIEW CARE CENTER-WELLS is a one-story building with a partial basement. The original building was built in 1961 and was determined to be of Type II (222) construction. In 1967 an addition was built with a partial basement and was determined to be of Type II (111) construction. In 1999 an addition was constructed and determined to be of Type III (000) construction. Because the original building and the additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building - Type II (000). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors, and spaces open to the corridors that is monitored for automatic fire department notification. In all the resident rooms there are smoke detectors that are connected to the fire alarm panel that provides a supervisor signal to the fire alarm panel and remote	K0000		07/06/2026

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K0000 Bldg. 01	Continued from page 2 annunciators at all nursing stations and an indicator light outside each resident room. The facility has a capacity of 30 beds and had a census of 20 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		07/06/2026
K0741 SS = E Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on document review, observation, and staff interview, the facility failed to enforce smoking policies per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.4. This deficient finding could have a patterned impact on the occupants within the facility.	K0741	K741 - Smoking Regulations Corrective Action The non-compliant smoking receptacle was removed and replaced with an approved metal, self-closing smoking receptacle that meets Life Safety Code requirements. The designated smoking area was inspected and found to be in compliance. 2. Residents Potentially Affected The designated smoking area was inspected to ensure no additional fire hazards existed. No additional concerns were identified. 3. Systemic changes The Smoking Policy was reviewed with department managers and applicable staff. Education was provided regarding designated smoking areas, proper disposal of smoking materials, routine inspection of the smoking area, and prompt reporting of any safety concerns. The Maintenance Director will include the smoking area during routine environmental and Life Safety rounds. 4. Monitoring The Maintenance Director or Administrator will complete weekly inspections of the designated smoking area for four (4) weeks beginning July 1, 2026, followed by monthly inspections for two (2) months. Audits will verify that the approved smoking receptacle remains in place and functional, the area remains free of combustible debris, and the Smoking Policy is being followed. Findings will be reviewed	07/07/2026

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K0741 SS = E Bldg. 01	Continued from page 3 Findings include: 1. On 06/03/2026 at 10:34 AM, it was revealed by observation that there were cigarettes butts discarded in a plastic trashcan near the designated smoking area. 2. On 06/03/2026 at 10:34 AM, it was revealed by observation that there was not a metal container with a self-closing lid in the designated smoking area. 3. On 06/03/2026 at 10:53 AM, it was revealed by document review that the facilities smoking policy was incomplete and missing information. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0741	Continued from page 3 during QAPI, and corrective action will be taken immediately if concerns are identified. Date of compliance: July 7, 2026.	07/07/2026
K0372 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/03/2026 at 10:47 AM, it was revealed by observation that there was a black cable penetrating in the smoke barrier located at the East wing that was unsealed.	K0372	K372 - Smoke Barrier Corrective Action The identified wall penetration was sealed using an approved fire-stop caulk in accordance with Life Safety Code requirements. The repair was completed and verified by Maintenance. 2. Residents Potentially Affected Maintenance inspected accessible smoke barrier penetrations throughout the facility. No additional deficiencies requiring correction were identified. 3. Systemic Changes Maintenance procedures were reviewed regarding identification and repair of wall and ceiling penetrations. Department managers were instructed to notify Maintenance immediately if any new penetrations or damaged walls, ceilings, or utility openings are identified during daily operations or environmental rounds. Fire stopping will be verified following or contractor work that creates wall or ceiling penetrations. 4. Monitoring The Maintenance Director or Administrator will conduct weekly inspections of smoke barrier	07/07/2026

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K0372 SS = D Bldg. 01	Continued from page 4 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0372	Continued from page 4 penetrations for four weeks beginning July 1, 2026, followed by monthly inspections for two months. Audits will verify smoke barriers remain intact and any new penetrations are repaired immediately using approved fire-stop materials. Findings will be reviewed during QAPI. Date of Compliance: July 7, 2026	07/07/2026
K0521 SS = D Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain an acceptable HVAC System per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1, and 9.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 06/03/2025 at 9:30 AM, it was revealed by observation that the corridors in the 1961 and 1967 buildings are being utilized as the supply air plenum for the resident rooms. Annual waiver has been approved in previous year. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0521	K521 - HVAC Corrective Action The facility reviewed the HVAC deficiency identified during survey and confirmed continued compliance with required preventive maintenance. The HVAC system was evaluated, and no resident safety concerns were identified. The facility will request a waiver from the State to assure that we are not violating 9.2. Responsible: Facility Maintenance Director and Administrator will secure the appropriate waiver from the State Fire Marshall's office. 2. Residents Potentially Affected Resident care areas served by the HVAC systems were reviewed. No additional concerns affecting resident health or safety were identified. 3. Systemic Changes The Maintenance Director reviewed the facility's preventative maintenance schedule and documentation requirements. Preventive maintenance records will continue to be maintained in accordance with manufacturer recommendations and applicable Life Safety Code requirements. Department managers were educated regarding prompt reporting of any ventilation or HVAC concerns. 4. Monitoring The Maintenance Director or Administrator will conduct weekly HVAC compliance reviews for four weeks beginning July 1, 2026, followed by monthly	07/07/2026

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K0521 SS = D Bldg. 01		K0521	Continued from page 5 reviews for two months. Preventive maintenance records and any HVAC concerns will be reviewed by the Administrator during QAPI meetings. Any identified deficiencies will be corrected immediately and documented. Date of Compliance: July 7, 2026	07/07/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 31, 2026

Administrator
PARKVIEW CARE CENTER
55 TENTH STREET SOUTHEAST
WELLS, MN 56097

RE: CCN: 245436
Cycle Start Date: June 3, 2026

Dear Administrator:

On July 29, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 - HVAC at the time of the June 4, 2026, standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us