Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 25, 2024

Administrator
Parkview Care Center
55 Tenth Street Southeast
Wells, MN 56097

RE: CCN: 245436
Cycle Start Date: August 2, 2024

Dear Administrator:

On September 18, 2024, the Minnesota Departments 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.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
August 21, 2024

Administrator
Parkview Care Center
55 Tenth Street Southeast
Wells, MN 56097

RE: CCN: 245436
Cycle Start Date: August 2, 2024

Dear Administrator:

On August 2, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

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
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 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 November 2, 2024 (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 February 2, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(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 On 7/22/24 through 7/25/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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.	E 000		
F 000	INITIAL COMMENTS On 7/22/24 through 7/25/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55936002C (MN104805) and H55936106C (MN105085). 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.	F 000		
F 572	Notice of Rights and Rules	F 572		9/3/24

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

Electronically Signed | 08/29/2024

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

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F 572 SS=D	Continued From page 1 CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide ongoing communication to residents about their rights (e.g., through resident groups) for 4 of 4 residents (R18, R25, R9, R22) who attended the council meetings. Findings include: Resident council meeting minutes were reviewed for the months of January through July 2024. Meeting minutes did not reflect resident rights having been included in meeting discussions. During the resident council meeting on 7/23/24,	F 572	F572 Notice of Rights and Rules 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R18, R25, R9 and R22 were provided with a copy of the resident right handbook. Education provided in resident council on the resident rights. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be	

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F 572	Continued From page 2 from 12:49 p.m. to 1:22 p.m., the following residents were in attendance: R18, R25, R9 and R22. All four residents stated they regularly attended resident council meetings and did not recall a time when resident rights had been discussed. All four residents stated they did not know where resident rights were posted in the facility, which were located in a hallway near the nurses station, across from the beauty salon. When informed of the location, R25 stated, "Oh, I think I know what you're talking about. I didn't know that was for us." According to Minimum Data Set (MDS) assessments: R18 - quarterly MDS dated 6/3/24, indicated R18 was cognitively intact. R25 - quarterly MDS dated 6/19/24, indicated R25 was cognitively intact. R9 - quarterly MDS dated 6/12/24, indicated R9 was cognitively intact. R22 - significant change MDS dated 5/28/24, indicated R22 had moderately impaired cognition. During an interview on 7/23/24 at 2:07 p.m., licensed social worker (LSW)-A stated she facilitated monthly resident council meetings. LSW-A stated when residents were admitted, they received a booklet on resident rights. LSW-A stated she didn't think residents looked at them because they were found in drawers when residents were discharged or passed away. While looking at older minutes, LSW-A stated she had not reviewed resident rights at a resident council meeting since 2022, and didn't know how that topic fell off the agenda. During an interview on 7/23/24 at 2:20 p.m., the director of nursing (DON) stated the facility did	F 572	affected. Education provided via a meeting held by the activity director. All residents that didn□t attend the meeting were provided a copy of their rights. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? All new residents will receive a copy of the resident rights in their admission packet. Resident rights will be discussed monthly at resident council meetings. Resident council meeting minutes will be posted. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The resident council meeting minutes will be reviewed monthly to ensure compliance. Results will be brought to QAPI for the recommendation of continuation of audit. Initial audit period of monthly for 3 months. 5.What is the date of completion? 9/3/24	

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F 572	Continued From page 3 not have a policy on resident council meetings and instead provided an undated page from the resident handbook. The page indicated the resident council group was one way for residents to communicate with the facility. It was an organization formed by the residents. The purpose was to provide a means for residents to share concerns, suggestions and ideas with other residents and staff. It also allowed the opportunity to participate in affairs and decisions that influence life each day.	F 572		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying	F 577		9/3/24

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F 577	Continued From page 4 information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure state agency (SA) survey results were available for 4 of 31 residents (R18, R25, R9, R22) who attended resident council meetings. This had the potential to affect all 31 residents and families that may wish to review the results. Findings include: During an observation on 7/23/24 at 11:30 a.m., observed the SA survey results binder at the east (main) entrance of the facility on the counter of an unmanned reception desk that was in a hallway of offices that is not a common area for residents. While the survey results binder may have been readily accessible to family members and legal representatives, results would generally only be accessible to residents if they were exiting or entering the building, or meeting with staff in one of the offices. During the resident council meeting on 7/23/24, from 12:49 p.m. to 1:22 p.m., the following residents were in attendance: R18, R25, R9 and R22. All four residents stated they regularly attended resident council meetings. None of the four residents were familiar with SA survey results nor did they know they had access to them. All four residents stated they did not know where SA survey results were located. According to Minimum Data Set (MDS) assessments: R18 - quarterly MDS dated 6/3/24, indicated R18 was cognitively intact.	F 577	F577 Right to Survey Results/Advocate Agency Info 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R18, R25, R9, and R22 were educated on the location of the facility□s survey results and advocacy information and where they are located in the facility. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected. Education was provided to all residents at the meeting provided by the social services director. All residents that didn't attend received a written copy of the education provided. All staff were also given the education of the location of these items. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? New admissions will be notified upon admission of the location of our survey results and the advocacy contact information. We have created a write up we will place into our admissions packet for every new admission moving forward explaining the location and the availability of them 24/7. The survey results and	

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F 577	Continued From page 5 R25 - quarterly MDS dated 6/19/24, indicated R25 was cognitively intact. R9 - quarterly MDS dated 6/12/24, indicated R9 was cognitively intact. R22 - significant change MDS dated 5/28/24, indicated R22 had moderately impaired cognition. Resident council minutes since the last SA survey were reviewed and included minutes from January through July 2024. Minutes were not available for September through November 2023, (unable to locate). No meeting was held in December 2023, due to a Covid-19 outbreak. Meeting minutes did not reflect discussion of SA survey results or the location of survey results. During an interview on 7/23/24 at 2:07 p.m., licensed social worker (LSW)-A stated she facilitated monthly resident council meetings and did not recall informing residents of their right to review SA survey results or informing them of the location of the survey binder. During an interview on 7/23/24 at 2:20 p.m., the director of nursing (DON) stated the facility did not have a policy on resident council meetings, and instead provided an undated page from the resident handbook. The page indicated the resident council group was one way for residents to communicate with the facility. It was an organization formed by the residents. The purpose was to provide a means for residents to share concerns, suggestions and ideas with other residents and staff. It also allowed the opportunity to participate in affairs and decisions that influence life each day. During an interview on 7/23/24 at 2:25 p.m., the	F 577	advocacy information locations will be reviewed every month at Resident Group moving forward as well. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Will audit the Resident group meeting minutes. Audit results will be brought to QAPI committee for further recommendation. Initial audit period will be 3 months. 5.What is the date of completion? 9/3/24	

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F 577	Continued From page 6 administrator was informed of findings and immediately relocated the binder to a countertop in the dining room. The administrator stated they would look for a permanent location that was easily accessible to residents.	F 577		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		9/3/24

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F 880	Continued From page 7 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident (R28) who had an indwelling catheter.	F 880	F880 Infection Prevention and Control 1.What corrective action will be accomplished for those residents found to	

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GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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F 880	Continued From page 8 Findings include: R28's significant change in status Minimum Data Set (MDS) assessment dated 6/13/24, identified moderately impaired cognition, dependent on staff for transfers, utilized a wheelchair, indwelling catheter, diagnoses of hip fracture, muscle weakness, and retention of urine. On 7/23/24 at 9:22 a.m., nursing assistant (NA)-A and NA-B entered R28's room without donning a gown or gloves. A magnet was observed on the outside of the room indicating enhanced barrier precautions were in place for R28 with personal protective equipment (PPE) supplies outside of R28's room. NA-A and NA-B were observed inside R28's room and donned gloves and completed a brief change for R28 with no gown observed. At approximately 9:30 a.m., NA-A confirmed a gown was not worn as expected when they assisted R28. NA-A stated R28 had a catheter and a gown and gloves was expected worn when providing cares and stated she made a mistake. NA-A stated the facility had provided training on wearing PPE in EBP resident rooms.. On 7/24/24 at 10:05 a.m., the director of nursing (DON) stated staff were expected to wear PPE for residents on EBP when completing cares. Facility Standard and Transmission Based Precautions policy dated 4/2/24, indicated: Enhanced barrier Precautions are needed for residents with .... indwelling urinary catheters. High Contact resident care activities include transfers, dressing, providing hygiene, changing briefs, or assisting with toileting.	F 880	have been affected by the deficient practice? Immediate education was provided to the staff member providing care to R28 on the policy and procedure related to EBP. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents on EBP have the potential to be affected. Reviewed all residents to verify which residents need EBP and the proper PPE and postings. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Education provided to all nursing staff at a nursing department meeting held on 8/6/24. All facility staff educated on EBP at an all staff meeting on 8/28. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or designee will audit the compliance of EBP protocols for R28 and 4 other residents on EBP weekly x 4 and monthly x 3. Audit results will be brought to QAPI committee for further recommendation. 5.What is the date of completion? 9/3/24	

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	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2024**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/31/2024. 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.	K 000		

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

Electronically Signed | 08/30/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. 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)	K 000		

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K 000	Continued From page 2 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 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 24 at the time of the survey.	K 000		
K 271 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	K 271	Preparation and/or execution of this plan	9/13/24

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K 271	Continued From page 3 facility failed to maintain facility discharge from exits per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/31/2024 between 9:30 AM and 12:30 PM, it was revealed by observation that the dinning room required exit northwest exit discharge walking surface has a over an half inch drop creating a uneven walking surface to public way. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 271	does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. K271 Discharge from Exits The corrective action taken for all residents was to implement a maintenance prevention and identification program/process that identifies the facility's failure to inspect and properly maintain exit discharges in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7 and 7.1.6.1.1. The facility identified that all residents have the potential to be impacted by not proactively identifying the facility's failure to inspect and properly maintain exit discharges. The measures that were put into place were the Environmental Services Coordinator and/or designees will visually observe exits for wear, tear, and generally unsafe conditions that present fall or trip hazards. A bid is being obtained from the cement contractor who specializes in smaller repair/replacement projects. Visual audits and inspections of the campus concrete and exits will be initiated into the	

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K 271	Continued From page 4	K 271	prevention and maintenance program to ensure this deficient practice does not reoccur. The facility will monitor/observe and then audit/document monthly the exit conditions at the facility for four months or until substantial compliance has been determined by the QAPI and/or QAA. Any results found not to be in compliance will be brought to the Director of Nursing, and Administrator immediately. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was identified and reported to QAPI on 8/13/2024 The plan of correction will be reported to QAA on 10/17/2024 The above corrective action measures will be completed on or before 9/13/2024	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321		9/13/24

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K 321	Continued From page 5 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.6.3.1, 8.4.3.2, and 8.4.4.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 07/31/2024 between 9:30 AM and 12:30 PM, it was revealed by observation that the following was found: 1. Storage room # 21 - has no self-closing device on door 2. Soiled utility room # 44 - door will not shut and latch	K 321	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. K321: Hazardous Areas-Enclosure Deficiency Identification The facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.6.3.1, 8.4.3.2, and 8.4.4.1.	

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K 321	Continued From page 6 An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 321	Corrective Action Immediate Actions Taken: The Maintenance Director ordered hinges on August 8, 2024, and they were replaced on August 13, 2024. The Maintenance Director ordered closures on August 6, 2024, and the deficient practice will be corrected on or before September 13, 2024. Inspected all hazardous rooms to ensure compliance with NFPA 101 standards. Repaired or replaced any deficient fire barriers, doors, and seals in hazardous rooms. Identification and Protection Measures: Conducted a facility-wide audit to identify other hazardous rooms that may not meet NFPA 101 standards. Implemented immediate corrective actions for any additional non-compliant rooms found during the audit. Ensured all residents were protected by verifying that all hazardous rooms are now compliant or will be by September 13, 2024. Systemic Changes: Updated the facility□s maintenance policy and checklist to include regular inspections of hazardous rooms, hinges, and closers on doors. Enhanced fire safety protocols to ensure continuous compliance with NFPA 101 standards.	

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K 321	Continued From page 7	K 321	Monitoring Methods and Quality Assurance: Established a schedule for quarterly audits of all hazardous rooms. Developed a checklist based on NFPA 101 standards to be used during inspections. Implemented a tracking system to document findings and corrective actions taken. Implementation and Compliance: Maintenance Supervisor: Responsible for conducting inspections and ensuring repairs are completed. Maintenance Director, Assistant Administrator, and/or designee: Oversees the audit process and ensures compliance with NFPA 101 standards. Facility Administrator: Ensures overall compliance and allocates resources for necessary repairs and training. Timelines: Quarterly audits: Ongoing, starting from August 13, 2024, and following through for four months or until substantial compliance has been achieved and determined by the QAPI and/or QAA. Documentation Maintained detailed records of all inspections, findings, and corrective actions taken. Documented training sessions and attendance records. Kept audit reports and compliance checklists on file for review.	

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K 321	Continued From page 8	K 321	Assessment and Ongoing Compliance: Scheduled follow-up inspections to ensure the effectiveness of corrective actions. Reviewed audit results and made necessary adjustments to protocols and training. Reported findings and compliance status to the facility□s Quality Assurance Committee on a quarterly basis. The deficiency was identified and reported to QAPI on 8/13/2024 The plan of correction will be reported to QAA on 10/17/2024 The above corrective action measures were completed on 9/13/2024 By implementing these corrective actions and systemic changes, the facility ensures compliance with NFPA 101 standards and enhances the safety and well-being of all residents	
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 a review of available documentation and	K 345	Preparation and/or execution of this plan	9/13/24

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K 345	Continued From page 9 staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 9.6.1.5, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1 and 14.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/31/2024 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that the facility did not have documentation showing that they have completed a semi-annual visual fire alarm inspection. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 345	does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. K345 Fire Alarm System-Testing and Maintenance The facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 9.6.1.5, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1 and 14.3.5. Corrective Action for Residents Affected Immediate Action Taken: A visual inspection of the fire alarm system was conducted immediately upon identification of the deficiency. The Maintenance Director did locate his visual inspection documentation after the survey exit. Any identified issues were promptly addressed and resolved to ensure the safety of all residents. Documentation: Inspection reports and corrective actions were documented and filed in the appropriate location for future reference. Corrective Action for Other Residents Identification: A comprehensive review of all	

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K 345	Continued From page 10	K 345	resident areas was conducted to ensure no other residents were affected by the deficiency. Protection Measures: Additional fire safety checks were performed in all resident areas to confirm the functionality of the fire alarm system. Systemic Changes Policy Update: The facility's fire alarm inspection policy was updated to ensure compliance with NFPA 101 and NFPA 72 standards. Process Change: A new protocol was established for regular fire alarm system inspections, including a detailed checklist and schedule. Monitoring and Quality Assurance Regular Audits: Monthly internal audits will be conducted to verify the fire alarm system's functionality and compliance with inspection schedules. Data Collection: Inspection results and any corrective actions will be logged and reviewed by the Quality Assurance Committee. Responsible Parties Implementation: The Maintenance Director is responsible for ensuring the fire alarm system is inspected according to the updated schedule and ensuring proper documentation is readily available and organized for inspection-related purposes. Compliance: The Quality Assurance Committee will oversee compliance and	

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K 345	Continued From page 11	K 345	effectiveness of the corrective actions. Ongoing Monitoring: Monthly audits begin immediately and continue indefinitely or until QAPI and/or QAA determine substantial compliance with documentation. Training and Education The Maintenance Director was educated by the Administrator regarding the importance of documentation organization and the availability of documentation during a compliance survey. Documentation Record Keeping: All inspection reports, corrective actions, and training records will be maintained in a centralized file for review. Compliance Logs: A compliance log will be kept to track inspection dates, findings, and resolutions. Follow-Up Plan Effectiveness Assessment: The Quality Assurance Committee will review audit results and compliance logs quarterly to assess the effectiveness of the corrective actions. Continuous Improvement: Any identified gaps or areas for improvement will be addressed promptly, and additional training or policy adjustments will be made as necessary.	

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K 345	Continued From page 12	K 345	The deficiency was identified and reported to QAPI on 9/13/2024 The plan of correction will be reported to QAA on 10/17/2024 The above corrective action measures were completed on 9/13/2024 By implementing these corrective actions, the facility ensures compliance with NFPA 101 and NFPA 72 standards, thereby enhancing the safety and well-being of all residents.	
K 521 SS=D	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 REQUIREMENT 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 07/31/2024 between 9:30 and 12:30 PM, 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	K 521	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. K521 HVAC	9/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	**55 TENTH STREET SOUTHEAST** **WELLS, MN 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
K 521	Continued From page 13 waiver has been approved in previous year. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 521	Corrective action taken includes an annual waiver for the use of corridors and supply air plenum for resident rooms. Measures put in place to ensure the practice does not recur include the use of a waiver. The facility will monitor to ensure solutions are sustained by completing an annual waiver. The person responsible is the maintenance director. The tentative deficiency was identified and reported to QAPI on 8/13/2024 The plan of correction will be reported to QAA on 10/17/2024 The above corrective action measures will be completed on or before 9/13/2024	