

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered April 13, 2021

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

RE: CCN: 245436

Cycle Start Date: February 8, 2021

Dear Administrator:

On April 12, 2021, the Minnesota Department of Health 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, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 2, 2021

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

RE: CCN: 245436

Cycle Start Date: February 8, 2021

Dear Administrator:

On February 8, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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:

Parkview Care Center - Wells March 2, 2021 Page 2

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
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 May 8, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

Parkview Care Center - Wells March 2, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by August 8, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 03/09/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER - WELLS SITESTADDRESS, CITY, STATE, ZIP CODE STENTH STREET SOUTHEAST WELLS, MN 56097 WELLS, MN 56097 WELLS, MN 56097 PREFIX FREGULATORY OR LSC IDENTIFYING INFORMATION) FOUND INITIAL COMMENTS On 2/8/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CPR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED with deficiency: H#5436013C (MN61057). Deficiency issued at F689. The following complaints were found to be UNSUBSTANTIATED. H#5436011C (MN60766) H#5436011C (MN60766) H#5436011C (MN60769) F689 Fee facility replance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 689 Fee of Accident Hazards/Supervision/Devices SS=D CFR(S): 483.25(d) (1)(2) SA83.25(d) Accidents. The facility must ensure that - LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE WELLS, MN 55097 STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STENTH STREET SOUTHEAS SCHOLD ACCIDENT. STENTH STREET SO		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS On 2/8/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 458, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED with deficiency: H#5436013C (MN61057). Deficiency issued at F689. H#5436014C (MN67495). Deficiency issued at F689. H#5436011C (MN60756) H#5436016C (MN67696) H#5436016C (MN67999) H#5436016C (MN68969) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Food Page 12 Page 12 Page 13 Pag			WELLS		55 TENTH STREET SOUTHEAST	•	2/00/2021
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The facility must ensure that -		CFR(s): 483.25(d)	(1)(2)	ГΌ	09		3/11/21
		The facility must er	nsure that -				(/0) P.775

Electronically Signed 03/09/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		E SURVEY PLETED
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F 689	§483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and a accidents. This REQUIREME by: Based on observative review, the facility causal factors for interventions were risk of falls for 1 or eviewed for accidented to provide a residents (R4) reventions include: R3's admission reduced to provide a resident vascular (paralysis of one shemiparesis (weak side of the body), understand or expectation of the body), understand or expectation of the body). R3's quarterly Minassessment dated having a baseline (BIMS) score of "cognitive impairments assist of two staffs."	resident environment remains thazards as is possible; and he resident receives adequate sistance devices to prevent. ENT is not met as evidenced ation, interview and document failed to assess and evaluate falls and failed to ensure implemented to reduce the faresidents (R3) who was lents. In addition, the facility dequate supervision for 1 of 2 iewed for elopement. cord indicated an admission ith diagnosis that included; accident (CVA) with hemiplegia side of the body) and kness or inability to move one aphasia (loss of ability to press speech), dyslexia (loss of ability to press speech), dyslexia (loss of ability to press speech), dyslexia (loss and peripheral pathy (damage to nerves press and pain, usually in hands in the remaining moderate ent). R3 required extensive for bed mobility, transfers and da wheelchair for mobility. R3	F 6	,	by the therapy and to the anon-slip poing at this as completed er mat placed in slip footwear. It is updated to the new so facility will been no further ents in the fall y resident has the DON and all fall inuse analysis	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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F 689	Continued From plast assessment.	age 2	F 6	notes section of each incid		
	identified R3 as haweak gait and over R3 utilizes a whee	essessment dated 2/3/21, aving a history of falls. R3 has a crestimates and forgets limits. Elchair for mobility and requires the assessment identified R3 as for falling		IDT (inter-disciplinary tear root cause analysis for an incomplete for current res DON and MDS Coordinate care plans. Fall interventi adequate and no updates	y that were idents. The or reviewed all ons were were needed.	
	impaired cognitive related to dementiliving (ADL's) defined weakness from a 1-2 staff and a way with bed mobility. being at risk for faweakness from a balance with transprevention of falls wearing clean eye environmental devithe resdient verbattransfer without as R3 had several facause analysis to factors or new interesting to demention of the resdient verbattransfer without as R3 had several facause analysis to factors or new interesting the resdient verbattransfer without as R3 had several facause analysis to factors or new interesting the resdient verbattransfer without as R3 had several facause analysis to factors or new interesting the resdient verbattransfer without as R3 had several facause analysis to factors or new interesting the resdient verbattransfer without as R3 had several factors or new interesting the resdient verbattransfer with verbat	st reviewed 9/23/20, indicated a function and thought process a. R3 had an activities of daily icit related to right sided stroke. R3 required assist of lker with transfers and 1-2 staff. The care plan identified R3 as lls related to right sided stroke. R3 had impaired sitions. Interventions listed for included; assure resident is glasses, encourage to use vices such as grab bars, give I reminders to not ambulate or esistance,		Policy and Procedure rela reviewed. The policy is ac changes were made. The IDT were educated on how thorough root cause analy incidents, including falls. included "10 Consideratio About When a Resident F was completed with all sta IDT to ensure new interve implemented after each fa was completed with all sta cause analysis and that evencouraged to provide inpervention. Education also staff will be informed when interventions are implemed Safety will meet quarterly falls in addition to other m resident safety in our com report recommendations to	dequate, and no staff nurses and w to complete a visis for all Education ns to Think falls". Education aff nurses and entions are fall. Education aff related to root everyone is put for fall to included how now ented. The and will evaluate atters of immunity. Will	
	R3 was found lyin The resident state floor. No injuries v interventions imple -A fall incident rep was found lying or	ort dated 8/9/20, indicated R3 n the floor next to her		Audits will be completed by Administrator weekly for the ensure 1) root cause analy for falls, 2) new intervention implemented after each father eviewed by the QAPI determine frequency of or	hree months to ysis is completed ins are all. Results will Committee to	
	wheelchair by the	bed. R3 stated she slid out of		F-689 Elopement:		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	` ′сом	E SURVEY PLETED
		245436	B. WING _			C 08/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2021
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PARKVIE	W CARE CENTER -	WELLS		WELLS, MN 56097		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
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F 689	Continued From pa	age 3	F 68	9		
	her wheelchair on	to the floor. No injuries were				
	noted. There were	no new interventions		The resident was placed on hou	ly	
	implemented.			checks. A pager system was pu		
				When the wander-guard is trigge		
		ort dated 9/1/20, indicated R3		send an alert to the pager and st		
		the floor between the		notified immediately. If the resid		
		d. R3 stated she was trying to ne wheelchair and slid on to the		attempts to leave the building via that is not within hearing distance		
		ere noted. There were no new		the staff will be notified through t		
	interventions imple			and can take action right away.	no pagor	
	-A fall incident repo	ort dated 10/6/20, indicated R3		The DON reviewed all residents	in the	
		the floor near the bathroom		facility. All residents who are an		
		m. The resident stated she		elopement risk have the potentia		
		elchair on to the floor. No		affected. All residents assessed	as being	
		I. There were no new		at risk for elopement have a		
	interventions imple	ementea.		wander-guard bracelet. The new	pager	
	Λ fall incident ren	ort dated 10/16/20, indicated		system will ensure are alerted immediately if any resident trigge	are the	
		on the floor in front of the bed.		wander-guard alarm.	13 1116	
		d she slid on to the floor. (did		Warrach guara alam.		
		from bed or wheelchair) No		Policies and procedures related	to	
	injuries were noted			elopement were reviewed. The		
	implemented to R3			elopement policy was updated to	include	
				use of pager as another means		
		rm to R3's wheelchair was		staff when a door alarm has bee		
		0/16/20, there was no		triggered. The Emergency policy		
		ermine why the resident		updated to include required use		
		out of her bed/wheelchair. In		as part of the wander-guard syst		
		e no specific interventions event R3 from further sliding		Preventive maintenance policy was updated to ensure there are ade		
	out of the bed/whe	•		supplies of pager and to ensure		
	Cat of the bod, Wile			in good working order. Nursing		
	Observation on 2/2	27/21, at 12:15 p.m. R3 was		educated on how to use the pag		
		chair in her room watching TV.		the importance of having it on th		
		straight up in her wheelchair		so they are immediately aware if		
	and observed to be	e leaning forward slightly R3		alarm was triggered. The Safety	•	
		p alarm on her wheelchair.		Committee will meet quarterly ar		
	There was no non-	slip device on the wheelchair.		evaluate elopement attempts in	addition	

NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER - WELLS SUMMARY STATEMENT OF DEFICIENCIES STENTH STREET SOUTHEAST WELLS, MN 56997		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER - WELLS STREET ADDRESS, CITY, STATE, ZIP CODE \$5 TENTH STREET SOUTHEAST WELLS, MN 56097 WELLS, MN 56097 WELLS, MN 56097 FRETIX TAG FROM PROVIDERS PLAN OF CORRECTION ((EACH DEPICIENCY MUSTS BE PRECEDED BY FULL TAG FROM REGULATORY OR LSC IDENTIFYING INFORMATION) FROM REGULATORY OR LSC IDENTIFY INFORMATION) FROM REGULATORY OR LAST AND THE CARD TO SHAP THE CARD THE ARMORD TO SHAP THE CARD THE CARD THE CARD THE CARD THE CARD THE CARD T				7. 501251	.,		С		
PARKVIEW CARE CENTER - WELLS STRETTADRESS. CITY, STATE, ZIP CODE 55 TENTH STREET SOUTHEAS WELLS, MN 56097 PROVIDER'S PLAN OF CORRECTION (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 4 R3 was unable to be interviewed due to impaired cognition. Interview on 2/8/21, at 12:15 p.m. nursing assistant (NA)-E indicated set was aware of R3's fall risk and current interventions. NA-E indicated R3 requires assistant of the state of the staff for one month to see if staff have the page on their person and to see if they are aware of how to use it. Then audits will be done each shift every two weeks frequently and confirmed most of R3's falls had been from sliding on to the floor from the bed or wheelchair. NA-E confirmed there were no non-silp interventions to R3's wheelchair or bed that she knew of. Interview on 2/8/21, at 12:30 p.m. the director of nursing (DON) confirmed R3's wheelchair or bed that she knew of. Interview on 2/8/21, at 12:30 p.m. the director of nursing (DON) confirmed R3's wheelchair or bed that she knew of. Interview on 2/8/21, at 12:30 p.m. the director of nursing (DON) confirmed R3's wheelchair or bed that she knew of. Review of the facility policy Falls and Fall Risk, Managing reviewed on 1/21, directed the staff to identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling, if falling recurs despite initial interventions, staff will implement additional			245436	B. WING					
C(A) D SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION PREFIX TAG PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PREFIX TAG	NAME OF	PROVIDER OR SUPPLIER	-	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ELS, MN 66097 TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) F 689 Continued From page 4 R3 was unable to be interviewed due to impaired cognition. Interview on 2/8/21, at 12:15 p.m. nursing assistant (NA)-E indicated she was aware of R3's fall risk and current interventions. NA-E indicated R3 requires assistance of staff with all transfers and seldom uses the call light for assistance. NA-E indicated R3 will attempt to transfer self frequently and confirmed most of R3's falls had been from sliding on to the floor from the bed or wheelchair. NA-E confirmed there were no non-slip interventions to R3's wheelchair or bed that she knew of. Interview on 2/8/21, at 12:30 p.m. the director of nursing (DON) confirmed R3's wheelchair clip alarm was not included in the plan of care nor were new interventions. The DON further confirmed most all of R3's falls occurred from either sliding out of bed or wheelchair, but no interventions had been reviewed specific to the cause. Review of the facility policy Falls and Fall Risk, Managing reviewed on 1/21, directed the staff to identify interventions, staff will implement additional	PARKVII	W CARE CENTER -	WELLS						
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current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on	F 689	R3 was unable to be cognition. Interview on 2/8/21 assistant (NA)-E in fall risk and current R3 requires assistant seldom uses the NA-E indicated R3 frequently and combeen from sliding of wheelchair. NA-E on non-slip intervention that she knew of. Interview on 2/8/21 nursing (DON) con alarm was not inclusiver new intervent falls. The DON indinterdisciplinary te falls to determine to implement new interconfirmed most all either sliding out of interventions had be cause. Review of the facility Managing reviewed identify interventions from falling complications from initial interventions or different interver current approach recauses cannot be intervented.	dicated she was aware of R3's tinterventions. NA-E indicated ance of staff with all transfers he call light for assistance. will attempt to transfer self firmed most of R3's falls had on to the floor from the bed or confirmed there were no ons to R3's wheelchair or bed I, at 12:30 p.m. the director of firmed R3's wheelchair clip uded in the plan of care nor tions implemented for R3's icated the facility am did not thoroughly review he causal factors of the falls, to erventions. The DON further of R3's falls occurred from the bed or wheelchair, but no been reviewed specific to the staff to the related to the resident's causes to try to prevent the g and to try to minimize in falling. If falling recurs despite, staff will implement additional intions, or indicate why the emains relevant. If underlying readily identified or corrected,	F 6	89	community. Will report recomment to QAPI. Audits will be completed weekly on shift for one month to see if staff hapager on their person and to see if are aware of how to use it. Then a will be done each shift every two w for one month and then each shift for one month. Results will be reviby the QAPI Committee to determif requency of ongoing audits. The committee will review policies and procedures to ensure revisions are to review for any on-going revisions.	each ave the they udits eeks monthly ewed ne QAPI		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED C
		245436	B. WING _		02	/08/2021
	PROVIDER OR SUPPLIER	WELLS		STREET ADDRESS, CITY, STATE, ZIP CO 55 TENTH STREET SOUTHEAST WELLS, MN 56097		
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F 689	assessment of the until falling is reduce reason for the contidentified as unavor R4's facesheet prindiagnosis of demer R4's quarterly Minicassessment dated severe cognitive in able to make self understand others, minimal difficulty he staff for bed mobilicomotion off the R4's most recent cof nursing (DON) delopement risk and safety awareness, disguise exits, stop building, and staff whour to know his whad a wanderguard alert staff of attempt R4's quarterly wand ated 11/11/20, warisk to wander. A progress note daindicated the faciliticitizen who stated east end of the buil Staff went outside the street close to without a coat. R4 back into the buildi	nature or category of falling, ced or stopped, or until the inuation of the falling is	F 68			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION	COM	E SURVEY IPLETED
		245436	B. WING				C 08/2021
	PROVIDER OR SUPPLIER EW CARE CENTER - N	WELLS		55 T	EET ADDRESS, CITY, STATE, ZIP CODE ENTH STREET SOUTHEAST LLS, MN 56097	, , ,	· · · · · · · · · · · · · · · · · · ·
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F 689	time outside was 10 elopement, staff im During an interview registered nurse (R in room 31, and "or stated R4 had a wa which would activate through an exit doo the alarm most of the resident room with During an interview licensed practical in to wander in the hast facility through an exit a wanderguard brawheelchair and this went through an exit alarm went off, the the nurse call light is staff knew which do LPN-A stated she walarm, especially with further down the hast got their attention, the marquee to see where spond to that doo During an interview nursing assistant (N wanderguard which exited the building always able to hear sounded if she was resident TV's were	on 2/8/21, at 12:00 p.m., the liked to wander." RN-A anderguard on his wheelchair the a door alarm if he went the time, but not if she was in a the door closed. on 2/8/21, at 12:10 p.m., turse (LPN)-A stated R4 liked llway and sometimes left the exit door. LPN-A stated R4 had celet attached to his activated an alarm when he it door. LPN-A added when the door being exited displayed on marquee too and this was how for a resident was exiting. Was not always able to hear the hen in a residents room or allway. LPN-A stated the alarm then staff were to look at the ich door was being exited and or. on 2/8/21, at 12:16 p.m., then staff were to look at the ich door was being exited and or. on 2/8/21, at 12:16 p.m., then staff were to look at the ich door was being exited and or. on 2/8/21, at 12:16 p.m., the door alarm when it in a residents room or if	F6	89			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED C
		245436	B. WING_		02	/08/2021
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F 689	through on 11/19/2 door with clear glass being able to hear exited the building adding that the ala building was hard to next to it. The DON supposed to alert subuilding, then staff light marquee to idstated there had be the doors and alart done. During an interview maintenance supe exit door alarm. The next to the door with but significantly mustated the alarm or were no speakers of MS-A stated the sy were no longer available been looking in system. MS-A admits allow the significant light mustated the sy were no longer available mustated the sy were mustated the sy were no longer available mustated the sy were mustated the sy were mustated the sy were no longer available mustated the sy were mustated the sy were mustated the sy were no longer available mustated the sy were mus	age 7 0; it was a double egress exit as. The DON admitted staff not the door alarm when a resident had been an issue for awhile, and the east end of the to hear unless standing right a stated the alarm was staff to a resident exiting the were to look at the nurse call entity which door. The DON the endiscussions about updating the masses are but it had not been a system but it had not been a system was loud standing the he inside egress door open, affled when closed. MS-A and sounded at the door; there elsewhere in the building. The stem was obsolete as parts allable. MS-A stated the facility into possibly replacing the littled that staff further down the likely hear this alarm when it	F 6	39		
	administrator state elopement incident the quality committed know if frontline state about not hearing to stated the nurse caupgraded, but the place and alarms, upgrading doors not state the place and alarms.	on 2/8/21, at 1:33 p.m. the d the DON informed him about is and they were discussed at iee. The administrator didn't aff were involved in discussions the door alarms. Administrator all light system had been project did not include the adding they had talked about ext. The administrator admitted ce the name of an exit door				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		245436	B. WING _		02	/08/2021	
	PROVIDER OR SUPPLIER	WELLS		STREET ADDRESS, CITY, STATE, ZIP COI 55 TENTH STREET SOUTHEAST WELLS, MN 56097			
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F 689	happened to be local During a telephone p.m., (RN)-B who heloped on 11/19/20 incident and that R RN-B stated they goneighbor that R4 who heard the alarm, as residents ready for so far away. During an interview services (SS)-A who state agency state after R4's elopement informed her they go they were in the room MS-A provided dist in the facility to the ast remaining to the compact of the comp	call light marquee unless they oking at it. e interview on 2/8/21, at 1:41 had been working when R4 of the east entrance. It is a phone call from a ras found on the side of street ouse. RN-B stated no one is they were all in rooms getting supper, adding the alarm was no completed the report to the disher received a call at home and on 11/19/20, adding staff did not hear the alarm because oms with residents. I ances from various locations alarm on the east exit door: hich was a resident room	F 68	39			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245436	B. WING _		02	C / 08/2021	
	PROVIDER OR SUPPLIER	WELLS		STREET ADDRESS, CITY, STATE, ZIP 655 TENTH STREET SOUTHEAST WELLS, MN 56097			
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F 689	3:04 p.m NA-A east hallway by roc3:07 p.m. (RN)-C nurses station3:08 p.m. (LPN)-nurses station During an interview administrator state 2020, that staff car when far down the rooms. The adminithe issue was still i facility had not ider being able to hear was exiting the buil admitted the trigge resident exiting the alarm; that an exit the nurse call light sufficient. Facility policy titled Missing Resident, 2018, indicated: 1. Residents at risk elopement will be recessary precauti 2. Staff will implem immediately upon cannot be located. Facility procedure (Wanderguard), undevices were place the resident directly for proper function.	did not hear alarm from the om 32 C did not hear alarm at east AB did not hear alarm at west AB did not hear exit door alarms hallway or when in resident strator added that addressing in the discussion phase and the notified a remedy for staff not a door alarm when a resident alding. The administrator in for staff to be alerted to a building was hearing the door door number scrolling across marquee would not alone be alarmed and staff will take from the forward of th	F 68				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245436	B. WING			C / 08/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 55 TENTH STREET SOUTHEAST WELLS, MN 56097	P CODE	00/2021
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F 689	Facility policy titled with revised date of to take after a residual.	Wandering and Elopement f March 2019, indicated steps dent is identified as missing. It w to prevent residents from	F6	89		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 2, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: UG0D11

Dear Administrator:

The above facility was surveyed on February 8, 2021 through February 8, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

Parkview Care Center - Wells March 2, 2021 Page 2

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program 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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mistago

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 03/09/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00784	B. WING		02/0) 8/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PARKVII	EW CARE CENTER - V	WELLS	H STREET SO MN 56097	DUTHEAST		
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2 000 Initial Comments			2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	to determine compl Your facility was fou with the MN State L your electronic plan	eviated survey was conducted iance with State Licensure. und to be NOT in compliance icensure. Please indicate in of correction that you have ers, and identify the date when				

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

03/09/21 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 12 UG0D11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00784	B. WING			C 08/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
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I AIXIXVII	EW OAKE CENTER -	WELLS,	MN 56097	,			
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2 000	Continued From pa	age 1	2 000				
	The following complaints were found to be SUBSTANTIATED: H#5436013C (MN61057), H#5436014C(MN67495) with a licensing order issued at MN Rule 4658.0520 Subp. 1						
	UNSUBSTANTIATI H#5436012C (MN6 (MN67959), H#543 Minnesota Departn	blaints were found to be ED: H#5436011C (MN60756), 61024), H#5436015C 66016C (MN68969). nent of Health is documenting					
	federal software. To assigned to Minnes Nursing Homes. Th	g Correction Orders using ag numbers have been sota state statutes/rules for ne assigned tag number					
	Tag." The state state listed in the "Summ column and replace	eft column entitled "ID Prefix atute/rule out of compliance is nary Statement of Deficiencies' es the "To Comply" portion of r. This column also includes	,				
	statute after the sta as evidence by." Fo	are in violation of the state atement, "This Rule is not met ollowing the surveyors findings Method of Correction and					
	You have agreed to receipt of State lice the Minnesota Dep	p participate in the electronic ensure orders consistent with					
	http://www.health.s obul.htm. The State delineated on the a	tate.mn.us/divs/fpc/profinfo/inf e licensing orders are attached Minnesota					
	you electronically. is necessary for Sta enter the word "CO	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please PRRECTED" in the box					
	electronic State lice heading completion	ou must then indicate in the ensure process, under the a date, the date your orders wilto electronically submitting to	I				

Minnesota Department of Health

STATE FORM UG0D11 If continuation sheet 2 of 12

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF I		00784			02/0	8/2021
	PROVIDER OR SUPPLIER	55 TENTH	STREET SO	STATE, ZIP CODE DUTHEAST		
PARKVIE	EW CARE CENTER - V	WELLS, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	is enrolled in ePOC not required at the state form. PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	artment of Health. The facility and therefore a signature is pottom of the first page of ARD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			3/17/21
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.					
	by: Based on observati review, the facility for causal factors for finterventions were in risk of falls for 1 of reviewed for accide failed to provide ad-	ent is not met as evidenced on, interview and document ailed to assess and evaluate alls and failed to ensure mplemented to reduce the 3 residents (R3) who was ents. In addition, the facility equate supervision for 1 of 2 ewed for elopement.		Corrected		

Minnesota Department of Health

STATE FORM UG0D11 If continuation sheet 3 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00784	B. WING			C 08/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER - W	/FLLS 55 TENTH	DRESS, CITY, S I STREET SC MN 56097	TATE, ZIP CODE DUTHEAST			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
date of 10/8/18, with cerebral vascular ac (paralysis of one sid hemiparesis (weakn side of the body), ap understand or expres (learning disorder), valutonomic neuropat resulting in numbnes and feet). R3's quarterly Minimassessment dated 1 having a baseline in (BIMS) score of "12' cognitive impairment assist of two staff for walking. R3 utilized had 2 or more falls elast assessment. R3's current fall asses identified R3 as having weak gait and overe R3 utilizes a wheeld staff assistance. The being at high risk for R3's care plan, last impaired cognitive for related to dementia. living (ADL's) deficit weakness from a string at risk for falls with bed mobility. The being at risk for falls	ord indicated an admission of diagnosis that included; ocident (CVA) with hemiplegia le of the body) and less or inability to move one obasia (loss of ability to less speech), dyslexia weakness and peripheral obasis and pain, usually in hands of the body in	2 830				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET SOUTHEAST WELLS, MN 56097 PREFIX FACTOR (EACH DEPTICINATION) 2 830 Continued From page 4 balance with transitions, Interventions listed for prevention of falls included, assure resident is wearing clean eyeglasses, encourage to use environmental devices such as grab bars, give the resident stated she silid out of her wheelchair on the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated \$/3/120, indicated R3 was found lying on the floor between the wheelchair on the floor for between the wheelchair on the floor. So injuries were noted. There were no new interventions implemented. -A fall incident report dated \$/1/20, indicated R3 was found lying on the floor between the whelchair on the floor. So injuries were noted. There were no new interventions implemented. -A fall incident report dated \$/1/20, indicated R3 was found lying on the floor next to her wheelchair on the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated \$/1/20, indicated R3 was found lying on the floor next to her wheelchair on the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated \$/1/20, indicated R3 was found lying on the floor between the wheelchair on the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated \$/1/20, indicated R3 was found lying on the floor between the wheelchair on the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated \$/1/20, indicated R3 was found lying on the floor near the bathroom doorway in her room. The resident stated she sid out of her wheelchair on to the floor. No injuries were noted. There were no new interventions implemented.		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES N 56097			00784		B. WING			_
CALID SUMMARY STATEMENT OF DETICICACIES ID PROVIDER'S PLAN OF CORRECTION CACH DETICICACY WISTS TER PERCEPCIBL BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRIPERLY TAGS THE APPROPRIATE TAGS COMPLETE TAGS CONTINUED THE APPROPRIATE DEFICIENCY 2 830 Continued From page 4 2 830 balance with transitions. Interventions listed for prevention of falls included; assure resident is wearing clean eveglasses, encourage to use environmental devices such as grab bars, give the resdient verbal reminders to not ambulate or transfer without assistance, R3 had several falls that did not include a root cause analysis to determine potential contributing factors or new intervention to prevent further falls. Falls included the following incidents: -A fall incident report dated 5/21//20, indicated R3 was found lying on the floor next to her bed. The resident stated she slid out of bed on to the floor, No injuries were noted. There were no new interventions implemented. -A fall incident report dated 9/1/20, indicated R3 was found lying on the floor next to her wheelchair not not the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated 9/1/20, indicated R3 was found lying on the floor between the wheelchair and bed. R3 stated she was trying to transfer self in to the wheelchair and slid on to the floor, No injuries were noted. There were no new interventions implemented. -A fall incident report dated 10/6/20, indicated R3 was found lying on the floor near the bathroom doorway in her room. The resident stated she slid out of her wheelchair not to the floor. No			WELLS	55 TENTH	STREET SO			
balance with transitions. Interventions listed for prevention of falls included; assure resident is wearing clean eyeglasses, encourage to use environmental devices such as grab bars, give the resident verbal reminders to not ambulate or transfer without assistance, R3 had several falls that did not include a root cause analysis to determine potential contributing factors or new intervention to prevent further falls. Falls included the following incidents: -A fall incident report dated 5/21//20, indicated R3 was found lying on the floor next to her bed. The resident stated she slid out of bed on to the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated 8/9/20, indicated R3 was found lying on the floor next to her wheelchair by the bed. R3 stated she slid out of her wheelchair on to the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated 9/1/20, indicated R3 was found lying on the floor between the wheelchair and bed. R3 stated she was trying to transfer self in to the wheelchair and slid on to the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated 10/6/20, indicated R3 was found lying on the floor next the bathroom dorway in her room. The resident stated she slid out of her wheelchair in the floor. No injuries were noted. There were no new interventions implemented.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDE	ENCIES ED BY FULL	ID PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLETE
interventions implemented. -A fall incident report dated 10/16/20, indicated	2 830	balance with transit prevention of falls in wearing clean eyegen environmental devithe resdient verbal transfer without ass R3 had several falls cause analysis to defactors or new interfalls included the formal fall incident reports as found lying. The resident state of floor. No injuries we interventions imple resident state of floor. No injuries we interventions imple for the floor. A fall incident reports found lying on wheelchair by the balance of the floor. A fall incident reports found lying on wheelchair and bed transfer self in to the floor. No injuries we interventions imple floor for the floor of th	tions. Intervention included; assure plasses, encouraces such as gral reminders to not sistance, Is that did not include the tetermine potention to preveollowing incident and the tetermine potential and	resident is ge to use o bars, give tambulate or lude a root al contributing nt further falls. So to her bed. The bed on to the were no new indicated R3 her he slid out of a slid on to the was trying to dislid on to the were no new indicated R3 not the was trying to dislid on to the were no new indicated R3 not the was trying to dislid on to the were no new indicated R3 not the was trying to dislid on to the were no new indicated R3 not the was trying to dislid on to the were no new indicated R3 not the were not the wer	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00784	B. WING			C 08/2021
	PROVIDER OR SUPPLIER	55 TENTH	STREET SC	STATE, ZIP CODE DUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	R3 was found lying The resident stated not specify if it was injuries were noted implemented to R3. Although a clip alar implemented on 10 assessment to dete continued to slide of addition, there were implemented to prefout of the bed/wheet. Observation on 2/2 sitting in her wheeld R3 was not sitting and observed to be noted to have a clip There was no non-R3 was unable to be cognition. Interview on 2/8/21 assistant (NA)-E indicated R3 frequently and confibeen from sliding of wheelchair. NA-E conon-slip intervention that she knew of.	on the floor in front of the bed. she slid on to the floor. (did from bed or wheelchair) No. A clip alarm was s wheelchair. In to R3's wheelchair was /16/20, there was no ermine why the resident ut of her bed/wheelchair. In a no specific interventions went R3 from further sliding elchair. In the room watching TV. Straight up in her wheelchair leaning forward slightly R3 alarm on her wheelchair. In the interviewed due to impaired the interviewed due to impaired the call light for assistance. Will attempt to transfer self irmed most of R3's falls had not the floor from the bed or onfirmed there were no ens to R3's wheelchair or bed at 12:30 p.m. the director of firmed R3's wheelchair or bed at 12:30 p.m. the director	2 830			

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AND DI AN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00784		B. WING		02/0) 8/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE			
PARKVIEW CARE CENTER - WELLS	55 TENTH WELLS, M	STREET SC N 56097	DUTHEAST			
(X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
interdisciplinary team did not thoro falls to determine the causal factors implement new interventions. The I confirmed most all of R3's falls occeither sliding out of bed or wheelche interventions had been reviewed specuse. Review of the facility policy Falls and Managing reviewed on 1/21, directed identify interventions related to the specific risks and causes to try to peresident from falling and to try to micomplications from falling. If falling initial interventions, staff will implement or different interventions, or indicated current approach remains relevant. Causes cannot be readily identified staff will try various interventions, be assessment of the nature or category until falling is reduced or stopped, or reason for the continuation of the faitentified as unavoidable. R4's facesheet printed on 2/8/21, in diagnosis of dementia without behase R4's quarterly Minimum Data Set (Nassessment dated 11/11/20, indicated severe cognitive impairment; clear able to make self understood and counderstand others. R4 had adequated minimal difficulty hearing, was deposited for bed mobility, transfers, wall locomotion off the unit, dressing an R4's most recent care plan printed of nursing (DON) on 2/8/21, indicate elopement risk and wanderer related	s of the falls, to DON further urred from air, but no pecific to the aid Fall Risk, and the staff to resident's revent the inimize recurs despite nent additional awhy the lf underlying or corrected, ased on bry of falling, or until the alling is andicated aviors. MDS) the director and the director and to ileting. by the director air the director and the director and the director and the director air the direc	2 830				

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STATE FORM UG0D11 If continuation sheet 7 of 12

AND DIANIOE CODDECTION I IDENTIFICATION NI IMPED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00784	B. WING		I	C 08/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARKVI	EW CARE CENTER - V	WELLS 55 TENTH WELLS, N	ISTREET SC IN 56097	DUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	building, and staff very hour to know his with had a wanderguard alert staff of attempt R4's quarterly wand dated 11/11/20, was risk to wander. A progress note daindicated the facility citizen who stated a east end of the build staff went outside the street close to twithout a coat. R4 very back into the building damn thing around time outside was 10 elopement, staff im During an interview registered nurse (R in room 31, and "or stated R4 had a was which would activate through an exit dood the alarm most of the staff of the staff of the wander in the hafacility through an exit dood the the wanderguard brack wheelchair and this went through an exalarm went off, the	signs on doors on east end of vere to check on R4 every hereabouts. In addition, R4 bracelet on his wheelchair to the to leave the facility. dering risk assessment score is 12, indicating R4 was a high ted 11/19/20, at 4:45 p.m. or received a phone call from a resident was outside on the ding wheeling down the street. To intervene and found R4 in the curb, in his wheelchair was resistant to being broughting, yelling "you can't do a here." Estimated length of 0 minutes. Following the plemented hourly checks. Ton 2/8/21, at 12:00 p.m., N)-A stated R4 used to reside in, he liked to wander." RN-A inderguard on his wheelchair is a door alarm if he went re time, but not if she was in a	2 830			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED	
00784 B. WING 02/0) 8/ 2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 55 TENTH STREET SOUTHEAST		
WELLS, MN 56097		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
staff knew which door a resident was exiting. LPN-A stated she was not always able to hear the alarm, especially when in a residents room or further down the hallway. LPN-A stated the alarm got their attention, then staff were to look at the marquee to see which door was being exited and respond to that door. During an interview on 2/8/21, at 12:16 p.m., nursing assistant (NA)-A stated R4 had a wanderguard which would activate an alarm if he exited the building. NA-A stated she was not always able to hear the door alarm when it sounded if she was in a residents room or if resident TV's were loud. During an interview on 2/8/21, at 12:39 p.m., the DON identified the east exit door that R4 went through on 111/9/20; it was a double egress exit door with clear glass. The DON admitted staff not being able to hear the door alarm when a resident exited the building had been an issue for awhile, adding that the alarm on the east end of the building was hard to hear unless standing right next to it. The DON stated the alarm was supposed to alert staff to a resident exiting the building, then staff were to look at the nurse call light marquee to identity which door. The DON stated there had been discussions about updating the doors and alarm system but it had not been done. During an interview on 2/8/21, at 12:42 p.m., maintenance supervisor (MS)-A sounded the east exit door alarm. The alarm was loud standing next to the door with the inside egress door open, but significantly muffled when closed. MS-A stated the alarm only sounded at the door; there were no speakers elsewhere in the building.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00-04	B. WING		С	
		00784	B. WING		02/0	8/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PARKVI	EW CARE CENTER - \	WELLS S5 TENTH WELLS, M	ISTREET SO IN 56097	DUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	were no longer availand been looking in system. MS-A adminal hallway would not list sounded. During an interview administrator stated elopement incident the quality committed know if frontline stated the nurse caupgraded, but the product and alarms, aupgrading doors and alarms, aupgrading doors not staff would not not scroll on the nurse happened to be looked. During a telephone p.m., (RN)-B who heloped on 11/19/20 incident and that RRN-B stated they go neighbor that R4 who by the neighbors heloped on the product of the alarm, as residents ready for so far away. During an interview services (SS)-A who state agency stated after R4's elopement.	ilable. MS-A stated the facility nto possibly replacing the itted that staff further down the ikely hear this alarm when it on 2/8/21, at 1:33 p.m. the did the DON informed him about and they were discussed at ee. The administrator didn't off were involved in discussions the door alarms. Administrator ill light system had been project did not include the adding they had talked about ext. The administrator admitted the name of an exit door call light marquee unless they oking at it. Interview on 2/8/21, at 1:41 and been working when R4, stated she recalled the 4 exited the east entrance, of a phone call from a as found on the side of street ouse. RN-B stated no one is they were all in rooms getting supper, adding the alarm was of on 2/8/21, at 1:50 p.m., social of completed the report to the did she received a call at home int on 11/19/20, adding staff lid not hear the alarm because	2 830			
		ances from various locations alarm on the east exit door:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00784	B. WING		II.	C 08/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
PARKVII	EW CARE CENTER - V	VFLLS	ISTREET SO In 56097	DUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	From room 32, who closest to the east of the east of the east exit does feetFrom east exit does walked to various proom 32, could bare only hear it because hear the alarm at the nurses station or we during this time:3:04 p.m NA-A east hallway by roo3:07 p.m. (RN)-C nurses station3:08 p.m. (LPN)-nurses station3:08 p.m. (LPN)-nurses station During an interview administrator stated 2020, that staff can when far down the rooms. The administrator stated rooms. The administrator stated company the stated stated the stated forms.	nich was a resident room exit = 122 feet or to east nurses station = 164 or to west nurses station = 319 or to west exit door = 449 feet est done on 2/8/21, at 3:00 d the alarm and two surveyors oints away from the alarm. At ely hear the alarm and could e was listening for it. Could not he east nurses station, west est exit. Staff interviewed	2 830			
	being able to hear a was exiting the build admitted the trigger resident exiting the alarm; that an exit of the nurse call light resufficient.	tified a remedy for staff not a door alarm when a resident ding. The administrator for staff to be alerted to a building was hearing the door door number scrolling across marquee would not alone be Emergency Procedure - with revised date of March				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
00784		B. WING		02/0) 8/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
PARKVII	EW CARE CENTER - V	VFLLS	ISTREET SO Un 56097	DUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	2018, indicated: 1. Residents at risk elopement will be madecessary precautive. 2. Staff will implemed immediately upon docannot be located. Facility procedure ti (Wanderguard), undevices were place the resident directly for proper function. maintained and ser wanderguard service. Facility policy titled with revised date of to take after a resided did not address how eloping. SUGGESTED MET The director of nurs review/revise policie falls, accidents and proper assessment implemented. The I educate staff on the system for evaluating implementation of the developed, with the brought to the facility Committee for review.	for wandering and/or nonitored and staff will take ons to ensure their safety. In the policy for missing resident discovery that a resident discover	2 830			

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