

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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		245436	B. WING _		02/	08/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	EW CARE CENTER - V	WELLS		55 TENTH STREET SOUTHEAST WELLS, MN 56097		
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F 000	INITIAL COMMENT	ΓS	F 00	00		
	at your facility to co investigation. Your	facility was found NOT to be in CFR Part 483, Requirements				
	SUBSTANTIATED H#5436013C (MN6 F689.	plaints were found to be with deficiency: \$1057). Deficiency issued at \$7495). Deficiency issued at				
	The following comp UNSUBSTANTIATE H#5436011C (MN6 H#5436012C (MN6 H#5436015C (MN6 H#5436016C (MN6	0756) 31024) 37959)				
	as your allegation of Department's acception enrolled in ePOC, y	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required the first page of the CMS-2567				
F 689	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with azards/Supervision/Devices	F 68	39		3/17/21
SS=D	CFR(s): 483.25(d)(§483.25(d) Accider The facility must en	nts.				
I ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE

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		(X3) DATE SURVEY COMPLETED	
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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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 689	Continued From plast assessment.	page 2	F 6	notes section of each inciental IDT (inter-disciplinary tear			
	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		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 dement living (ADL's) def weakness from a 1-2 staff and a wa with bed mobility. being at risk for fa weakness from a balance with transprevention of falls wearing clean eye environmental det the resdient verbatransfer without as R3 had several fa cause analysis to factors or new interesting to demend the resdient verbatransfer without as R3 had several fa cause analysis to factors or new interesting the resdient verbatransfer without as R3 had several factors or new interesting the resdient verbatransfer without as R3 had several factors or new interesting the resdient verbatransfer without as R3 had several factors or new interesting the resdient verbatransfer without as R3 had several factors or new interesting the resdient verbatransfer without as R3 had several factors or new interesting the resdient verbatransfer with ver	st reviewed 9/23/20, indicated a function and thought process ia. 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 alls related to right sided stroke. R3 had impaired sitions. Interventions listed for included; assure resident is eglasses, encourage to use vices such as grab bars, give all reminders to not ambulate or essistance,		Policy and Procedure rela reviewed. The policy is acchanges were made. The IDT were educated on how thorough root cause analy incidents, including falls. included "10 Consideration About When a Resident F was completed with all state IDT to ensure new intervet implemented after each fawas completed with all state cause analysis and that even couraged to provide inpure prevention. Education also staff will be informed when interventions are implemed Safety will meet quarterly falls in addition to other m resident safety in our commendations 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 veryone is out for fall to included how now ented. The and will evaluate atters of imunity. 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 fabe reviewed by the QAPI determine frequency of or	hree months to ysis is completed ins are all. Results will Committee to		
		bed. R3 stated she slid out of		F-689 Elopement:			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	` ′сом	(X3) DATE SURVEY COMPLETED	
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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		Warra Guara diami.			
		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	L IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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PARKVIEW CARE CENTER - WELLS STRETTADRESS. CITY, STATE, ZIP CODE 55 TENTH STREET SOUTHEAS WELLS, MN 56097 PROVIDER'S PLAN OF CORRECTION (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 staff to the staff to implement new interventions to R3's wheelchair nable been from sliding on to the floor from the bed or wheelchair. NA-E confirmed most of R3's falls had been from sliding on to the floor from the bed or on-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 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 were new interventions implemented for R3's falls. The DON indicated the facility interdisciplinary team did not throughly review falls to determine the causal factors of the falls, to implement 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 slaff 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					
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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		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL		1 ' '	IPLE CONSTRUCTION IG		COMPLETED	
		245436	B. WING _		02	/08/2021
	PLAN OF CORRECTION 245436 ME OF PROVIDER OR SUPPLIER RKVIEW CARE CENTER - WELLS (4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODI 55 TENTH STREET SOUTHEAST WELLS, MN 56097			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
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, sed or stopped, or until the cinuation of the falling is idable ated on 2/8/21, indicated antia without behaviors. The mum Data Set (MDS) 11/11/20, indicated R4 had apairment; clear speech, was understood and could R4 had adequate vision, earing, was dependent upon ty, transfers, walking, unit, dressing and toileting. The plan printed by the director on 2/8/21, indicated R4 was and wanderer related to impaired Interventions included: To signs on doors on east end of were to check on R4 every hereabouts. In addition, R4 d bracelet on his wheelchair to obts to leave the facility. The dering risk assessment score is 12, indicating R4 was a high a resident was outside on the liding wheeling down the street.	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245436	B. WING				08/2021
	PROVIDER OR SUPPLIER	WELLS		55 TENTH	ODRESS, CITY, STATE, ZIP CODE STREET SOUTHEAST MN 56097	1 02	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 689	time outside was 1 elopement, staff im During an interview registered nurse (Fin room 31, and "ol stated R4 had a way which would activathrough an exit door the alarm most of the resident room with During an interview licensed practical into wander in the hafacility through an exalurm went off, the the nurse call light staff knew which do LPN-A stated she walarm, especially where down the hagot their attention, marquee to see where spond to that door During an interview nursing assistant (I wanderguard which exited the building always able to hear sounded if she was resident TV's were	O minutes. Following the aplemented hourly checks. Y on 2/8/21, at 12:00 p.m., RN)-A stated R4 used to reside in, he liked to wander." RN-A anderguard on his wheelchair te a door alarm if he went or. RN-A stated she could hear he time, but not if she was in a the door closed. Y on 2/8/21, at 12:10 p.m., nurse (LPN)-A stated R4 liked allway and sometimes left the exit door. LPN-A stated R4 had celet attached to his activated an alarm when he door being exited displayed on marquee too and this was how or a resident was exiting. Was not always able to hear the then in a residents room or allway. LPN-A stated the alarm then staff were to look at the nich door was being exited and or. Y on 2/8/21, at 12:16 p.m., NA)-A stated R4 had a na would activate an alarm if he NA-A stated she was not a the door alarm when it is in a residents room or if	F6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		245436	B. WING_		02	/08/2021	
	PROVIDER OR SUPPLIER EW CARE CENTER -	WELLS		STREET ADDRESS, CITY, STATE, ZIP CO 55 TENTH STREET SOUTHEAST WELLS, MN 56097			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
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 must be supplied to the system. MS-A admits allow the system. MS-A admits allow the significant light must be supplied to the system. MS-A admits allow the system. MS-A admits allow the system. MS-A admits allow the system.	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 as 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					

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		245436	B. WING _		02	2/08/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 55 TENTH STREET SOUTHEAST WELLS, MN 56097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	scroll on the nurse happened to be look During a telephone p.m., (RN)-B who heloped on 11/19/20 incident and that RRN-B stated they gneighbor that R4 who by the neighbors heard the alarm, a residents ready for so far away. During an interview services (SS)-A who State agency state after R4's elopement informed her they were in the rook MS-A provided distinct the facility to the refrom room 32, which closest to the east refrom east exit do feet refrom east exit do feet refrom east exit do feet room 32, could baronly hear it because hear the alarm at the services of the services of the services of the east refrom east exit do feet refrom e	call light marquee unless they oking at it. e interview on 2/8/21, at 1:41 had been working when R4 or stated she recalled the extention at a phone call from a gras found on the side of street ouse. RN-B stated no one is they were all in rooms getting a supper, adding the alarm was a completed the report to the disher received a call at home ent on 11/19/20, adding staff did not hear the alarm because oms with residents. Itances from various locations alarm on the east exit door: which was a resident room	F 68	39		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. 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		, , , , , , , , , , , , , , , , , , , ,	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
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:			TIPLE CONSTRUCTION	COV	(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
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
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

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00784	B. WING		02/0	8/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PARKVI	EW CARE CENTER - V	VELLS WELLS, N	ISTREET SO In 56097	JUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000 Initial Comments		2 000				
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department.	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess					
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt 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

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 t. BOILBIITO.			
		00784	B. WING		02/0	8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DARKVII.	EW CARE CENTER - V	WELLS 55 TENTH	STREET SO	DUTHEAST		
WELLS, I			IN 56097			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: H#5436014C(MN6) issued at MN Rule The following comp UNSUBSTANTIATE H#5436012C (MN6) (MN67959), H#543 Minnesota Departm	blaints were found to be ED: H#5436011C (MN60756), 1024), H#5436015C 6016C (MN68969). nent 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with					
	http://www.health.s	artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf ice licensing orders are				
	delineated on the a Department of Hea you electronically.	ttached Minnesota Ith orders being submitted to Although no plan of correction				
	enter the word "CO available for text. You electronic State lice	RRECTED" in the box ou must then indicate in the ensure process, under the				
		date, the date your orders will o electronically submitting to				

Minnesota Department of Health

STATE FORM UG0D11 If continuation sheet 2 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00784	B. WING		C 02/08/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARKVI	EW CARE CENTER - V	VELLS 55 TENTH WELLS, M	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE HE APPROPRIATE	
2 000	the Minnesota Depais enrolled in ePOC not required at the I 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 RD THE HEADING OF THE	2 000			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			3/17/21
	by: Based on observati review, the facility facausal factors for f interventions were i risk of falls for 1 of reviewed for accide	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 nts. 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) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00784	B. WING			C 08/2021
	PROVIDER OR SUPPLIER EW CARE CENTER - N	WELLS 55 TENT	DDRESS, CITY, ST H STREET SO MN 56097			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Findings include: R3's admission rec date of 10/8/18, wit cerebral vascular a (paralysis of one sichemiparesis (weak side of the body), a understand or expr (learning disorder), autonomic neuroparesulting in numbre and feet). R3's quarterly Minimassessment dated having a baseline in (BIMS) score of "12 cognitive impairme assist of two staff walking. R3 utilized had 2 or more falls last assessment. R3's current fall assidentified R3 as have weak gait and over R3 utilizes a wheelest staff assistance. The being at high risk for R3's care plan, last impaired cognitive related to demential living (ADL's) deficience as 1-2 staff and a walk with bed mobility. The ing at risk for fall	ord indicated an admission h diagnosis that included; ccident (CVA) with hemiplegia de of the body) and ness or inability to move one phasia (loss of ability to ess speech), dyslexia weakness and peripheral thy (damage to nerves ess and pain, usually in hands and peripheral thy (damage to nerves ess and pain, usually in hands are mum Data Set (MDS) 11/11/20, identified R3 as nerview for mental status [2]" (meaning moderate ent). R3 required extensive for bed mobility, transfers and a wheelchair for mobility. R3 either since admission or the sessment dated 2/3/21, wing a history of falls. R3 has a estimates and forgets limits. Chair for mobility and requires a sessessment identified R3 as				

Minnesota Department of Health

STATE FORM UG0D11 If continuation sheet 4 of 12

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 55 TENTH STREET SOUTHEAST WELLS, MM 56097 [KA) ID SUMMARY STATEMENT OF DEFICIENCIES WELLS, MM 56097 [KA) ID PREFIX (RACH DEPICIENCY MLST SEP PRECEDED BY FULL TAGS Ontinued 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 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 interventions in her 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 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 how to the rewheelchair 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 between 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 donway in her room. The resident stated she	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED			
PARKVIEW CARE CENTER - WELLS (X4) ID PREFIX TAG (X4) ID PREFIX TAG (X5) (CAOH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 4 balance with transitions. Interventions listed for prevention of falls included; assure resident is wearing clean eyeqlasses, 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 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 sex to 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 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			00784		B. WING				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 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 slid out of 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			WELLS	55 TENTH	I 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 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 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 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	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED I	BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE	
slid out of her wheelchair on to the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated 10/16/20, indicated	2 830	balance with transit prevention of falls in wearing clean eyeg environmental devithe resdient verbal transfer without ass R3 had several falls cause analysis to d factors or new interFalls included the ferballs included the ferball incident reports was found lying on wheelchair by the ball her wheelchair on the implemented. -A fall incident reports was found lying on wheelchair and become implemented. -A fall incident reports found in the power of the foor. No injuries we interventions implemented interventions interventions implemented interventions implemented interventions interventions interventions interventions interventions interventions int	cions. Interventions included; assure reallasses, encourage ces such as grab by reminders to not a sistance, Is that did not include etermine potential vention to prevent collowing incidents: It dated 5/21//20, on the floor next to a she slid out of bed ere noted. There we mented. It dated 8/9/20, incompany the floor next to he ded. R3 stated she to the floor. No injurate he floor between the floor between the floor between the floor head of the floor head. There we mented. It dated 10/6/20, incompany the floor near the floor head. There we mented. It dated 10/6/20, incompany the floor near the floor to the floor. There were no near the floor near the f	sident is to use pars, give mbulate or de a root contributing further falls. Indicated to her bed. Indicated to her bed. Indicated R3 er slid out of ries were no new dicated R3 the las trying to slid on to the ere no new	2 830				

Minnesota Department of Health

STATE FORM UG0D11 If continuation sheet 5 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY PLETED		
				D WING			C	
		00784		B. WING		02/0	08/2021	
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S I STREET S(STATE, ZIP CODE			
PARKVII	EW CARE CENTER - \	NELLS		IN 56097	DUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 5		2 830				
	The resident stated not specify if it was injuries were noted implemented to R3	's wheelchair.	. (did r) No					
	Although a clip alarm to R3's wheelchair was implemented on 10/16/20, there was no assessment to determine why the resident continued to slide out of her bed/wheelchair. In addition, there were no specific interventions implemented to prevent R3 from further sliding out of the bed/wheelchair.							
	Observation on 2/27/21, at 12:15 p.m. R3 was sitting in her wheelchair in her room watching TV. R3 was not sitting straight up in her wheelchair and observed to be leaning forward slightly R3 noted to have a clip alarm on her wheelchair. There was no non-slip device on the wheelchair. R3 was unable to be interviewed due to impaired cognition.							
	assistant (NA)-E indicated risk and current R3 requires assistated and seldom uses the NA-E indicated R3 frequently and confibeen from sliding owheelchair. NA-E confiber from sliding owheelchair.	, at 12:15 p.m. nursing dicated she was aware interventions. NA-E in nce of staff with all transe call light for assistance will attempt to transfer simmed most of R3's fall n to the floor from the bonfirmed there were nons to R3's wheelchair of	dicated esfers ce. self s had oed or					
	nursing (DON) con alarm was not inclu	, at 12:30 p.m. the directifications, at 12:30 p.m. the directions in the plan of care ions implemented for Recated the facility	clip nor					

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STATE FORM UG0D11 If continuation sheet 6 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00784	B. WING		l l	C 08/2021
	PROVIDER OR SUPPLIER	55 TENTH	STREET SO	TATE, ZIP CODE PUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	interdisciplinary tea falls to determine the implement new inter- confirmed most all either sliding out of interventions had be cause. Review of the facility Managing reviewed identify interventions specific risks and content from falling complications from initial interventions, or different intervent current approach recauses cannot be a staff will try various assessment of the until falling is reduct reason for the contilidentified as unavoid R4's facesheet print diagnosis of demer R4's quarterly Minimassessment dated severe cognitive imable to make self understand others. Minimal difficulty he staff for bed mobility locomotion off the unavoid R4's most recent case of nursing (DON) of elopement risk and	am did not thoroughly review ne causal factors of the falls, to erventions. The DON further of R3's falls occurred from bed or wheelchair, but no een reviewed specific to the cy policy Falls and Fall Risk, I on 1/21, directed the staff to s related to the resident's auses to try to prevent the g and to try to minimize falling. If falling recurs despite staff will implement additional tions, or indicate why the emains relevant. If underlying eadily identified or corrected, interventions, based on nature or category of falling, ed or stopped, or until the nuation of the falling is	2 830			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 55 TENTH STREET SOUTHEAST WELLS, MN 56097 (K4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 7 disguise exits, stop signs on doors on east end of building, and staff were to check on R4 every hour to know his whereabouts. In addition, R4 had a wanderguard bracelet on his wheelchair to alert staff of attempts to leave the facility. R4's quarterly wandering risk assessment score dated 11/11/20, was 12, indicating R4 was a high risk to wander. A progress note dated 11/11/20, at 4:45 p.m. indicated the facility received a phone call from a citizen who stated a resident was outside on the east end of the building wheeling down the street. Staff went outside to intervene and found R4 in the street close to the curb, in his wheelchair without a coat. R4 was resistant to being brought back into the building, yelling "you can't do a damn thing around here." Estimated length of time outside was 10 minutes. Following the elopement, staff implemented hourly checks. During an interview on 2/8/21, at 12:00 p.m., registered nurse (RN)-A stated R4 had a wanderguard on his wheelchair wester and a wanderguard on his wheelchair	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
PARKVIEW CARE CENTER - WELLS 55 TENTH STREET SOUTHEAST WELLS, MN 56097 (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE 2 830 Continued From page 7 2 830 2 830 disguise exits, stop signs on doors on east end of building, and staff were to check on R4 every hour to know his whereabouts. In addition, R4 had a wanderguard braceled on his wheelchair to alert staff of attempts to leave the facility. R4's quarterly wandering risk assessment score dated 11/11/20, was 12, indicating R4 was a high risk to wander. A progress note dated 11/19/20, at 4:45 p.m. indicated the facility received a phone call from a citizen who stated a resident was outside on the east end of the building wheeling down the street. Staff went outside to intervene and found R4 in the street close to the curb, in his wheelchair without a coat. R4 was resistant to being brought back into the building, yelling "you can't do a damn thing around here." Estimated length of time outside was 10 minutes. Following the elopement, staff implemented hourly checks. During an interview on 2/8/21, at 12:00 p.m., registered nurse (RN)-A stated R4 used to reside in room 31, and "0h, he liked to wander." RN-A			00784	B. WING			
(X4) ID PREFIX TAG (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PEPLL (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 7 disguise exits, stop signs on doors on east end of building, and staff were to check on R4 every hour to know his whereabouts. In addition, R4 had a wanderguard bracelet on his wheelchair to alert staff of attempts to leave the facility. R4's quarterly wandering risk assessment score dated 11/11/20, was 12, indicating R4 was a high risk to wander. A progress note dated 11/19/20, at 4:45 p.m. indicated the facility received a phone call from a citizen who stated a resident was outside on the east end of the building wheeling down the street. Staff went outside to intervene and found R4 in the street close to the curb, in his wheelchair without a coat. R4 was resistant to being brought back into the building, yelling "you can't do a damn thing around here." Estimated length of time outside was 10 minutes. Following the elopement, staff implemented hourly checks. During an interview on 2/8/21, at 12:00 p.m., registered nurse (RN)-A stated R4 used to reside in room 31, and "oh, he liked to wander." RN-A	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 7 disguise exits, stop signs on doors on east end of building, and staff were to check on R4 every hour to know his whereabouts. In addition, R4 had a wanderguard bracelet on his wheelchair to alert staff of attempts to leave the facility. R4's quarterly wandering risk assessment score dated 11/11/20, was 12, indicating R4 was a high risk to wander. A progress note dated 11/19/20, at 4:45 p.m. indicated the facility received a phone call from a citizen who stated a resident was outside on the east end of the building wheeling down the street. Staff went outside to intervene and found R4 in the street close to the curb, in his wheelchair without a coat. R4 was resistant to being brought back into the building, yelling "you can't do a damn thing around here." Estimated length of time outside was 10 minutes. Following the elopement, staff implemented hourly checks. During an interview on 2/8/21, at 12:00 p.m., registered nurse (RN)-A stated R4 used to reside in room 31, and "oh, he liked to wander." RN-A	PARKVI	EW CARE CENTER - V	VFLLS		DUTHEAST		
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which would activate a door alarm if he went through an exit door. RN-A stated she could hear the alarm most of the time, but not if she was in a resident room with the door closed. During an interview on 2/8/21, at 12:10 p.m., licensed practical nurse (LPN)-A stated R4 liked to wander in the hallway and sometimes left the facility through an exit door. LPN-A stated R4 had a wanderguard bracelet attached to his wheelchair and this activated an alarm when he went through an exit door. LPN-A added when the alarm went off, the door being exited displayed on the nurse call light marquee too and this was how	2 830	disguise exits, stop building, and staff whour to know his whad 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 buil Staff went outside the street close to twithout a coat. R4 who back into the building damn thing around time outside was 10 elopement, staff im During an interview registered nurse (Rin room 31, and "or stated R4 had a wawhich would activated through an exit doo the alarm most of the sident room with the street close to twithout a coat. R4 which would activated R4 had a wawhich would activated R5 had a wawhich would activated R6 had a wawhich would activated R6 had a wawhich would activated R6 had a wawhich would activated R7 had a wawhich would activated R6 had a wawhich would activated R6 had a wawhich would activated R6 had a wawhich would activate through an exit door the had a 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 its to leave the facility. dering risk assessment score is 12, indicating R4 was a high 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 brought ing, yelling "you can't do a here." Estimated length of minutes. Following the plemented hourly checks. on 2/8/21, at 12:00 p.m., N)-A stated R4 used to reside in the liked to wander." RN-A inderguard on his wheelchair is a door alarm if he went in RN-A stated she could hear in the time, but not if she was in a the door closed. on 2/8/21, at 12:10 p.m., urse (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 being exited displayed on				

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STATE FORM UG0D11 If continuation sheet 8 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
					С	
		00784	B. WING		02/0	8/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PARKVI	EW CARE CENTER - \	WELLS 55 TENTH WELLS, N	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	staff knew which do LPN-A stated she walarm, especially wanther down the hagot their attention, the marquee to see who respond to that door During an interview nursing assistant (Nownderguard which exited the building, always able to hear sounded if she was resident TV's were During an interview DON identified the through on 11/19/20 door with clear glass being able to hear the exited the building adding that the alar building was hard to next to it. The DON supposed to alert shoulding, then staff light marquee to identified the doors and alarm done. During an interview maintenance super exit door alarm. The next to the door with but significantly mustated the alarm on stated the alarm on the stated the alarm of the	poor a resident was exiting. I 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. I on 2/8/21, at 12:16 p.m., NA)-A stated R4 had a nawould activate an alarm if he NA-A stated she was not the door alarm when it in a residents room or if				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00784	B. WING		02/0) 8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
PARKVIE	PARKVIEW CARE CENTER - WELLS 55 TENT WELLS,			DUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	were no longer ava had been looking ir system. MS-A adm hallway would not li sounded. During an interview administrator stated elopement incident the quality committe know if frontline sta about not hearing the stated the nurse caupgraded, but the product the product of the	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 d the DON informed him about and they were discussed at ee. The administrator didn't off were involved in discussions he 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 call light marquee unless they iking at it.	2 830			
	happened to be looking at it. During a telephone interview on 2/8/21, at 1:41 p.m., (RN)-B who had been working when R4 eloped on 11/19/20, stated she recalled the incident and that R4 exited the east entrance. RN-B stated they got a phone call from a neighbor that R4 was found on the side of street by the neighbors house. RN-B stated no one heard the alarm, as they were all in rooms getting residents ready for supper, adding the alarm was so far away. During an interview on 2/8/21, at 1:50 p.m., social services (SS)-A who completed the report to the State agency stated she received a call at home after R4's elopement on 11/19/20, adding staff informed her they did not hear the alarm because they were in the rooms with residents. MS-A provided distances from various locations					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(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	-	
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)	IOULD BE	(X5) COMPLETE DATE
2 830	From room 32, who closest to the east of the east exit do feetFrom east exit do feet p.m., MS-A sounde walked to various proom 32, could bare only hear it because hear the alarm at the nurses station or with the feast hallway by roo3:04 p.m NA-A feast hallway by roo3:07 p.m. (RN)-Conurses station3:08 p.m. (LPN)-Inurses station3:0	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 be east nurses station, west est exit. Staff interviewed did not hear alarm from the m 32 did not hear alarm at east B did not hear alarm at west on 2/8/21, at 4:53 p.m., the d they have known since April not hear exit door alarms hallway or when in resident strator added that addressing in the discussion phase and the tified a remedy for staff not	2 830			
	was exiting the built admitted the trigger resident exiting the alarm; that an exit of the nurse call light resufficient.	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 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00784	B. WING			C 08/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARKVII	EW CARE CENTER - V	VELLS	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)	IOULD 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. Ent policy for missing resident iscovery that a resident stated, indicated wanderguard d on an assistive device or to and would be checked daily. Other equipment was to be viced by maintenance and/or se technician. Wandering and Elopement March 2019, indicated steps ent is identified as missing. It was to prevent residents from the procedures related to resident supervision to assure and interventions are being DON or designee, could be policies and procedures. And and monitoring consistent these policies could be results of these audits being ty's Quality Assurance	2 830			

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