Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 3, 2023

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

RE: CCN: 245436
Cycle Start Date: January 18, 2023

Dear Administrator:

On February 17, 2023, we notified you a remedy was imposed. On February 23, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 21, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 18, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 17, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 1, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 31, 2023

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

RE: CCN: 245436
Cycle Start Date: January 18, 2023

Dear Administrator:

On January 18, 2023, a survey was completed at your facility by the Minnesota Department of Health 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:

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by April 18, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 18, 2023 (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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING _____ B. WING _____	C 01/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/18/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H54367715C (MN83958), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaint was found to be UNSUBSTANTIATED: H54367397C (MN89938 and MN89960). The following complaint was found to be UNSUBSTANTIATED, however related deficiencies were cited. H54367616C (MN90147), with a deficiency cited at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		2/21/23

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

Electronically Signed | 02/09/2023

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

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F 609	Continued From page 1 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of abuse was reported to the state agency (SA) within 2 hours, in accordance with established policies and procedures, for 1 of 1 resident (R3) reviewed for an allegation of staff to resident sexual abuse. Findings include: R3's facesheet printed on 1/18/23, included	F 609	F609- Reporting of Alleged Violations It is the facility's intent to comply with the regulation to report the required alleged violations. The corrective action taken for R3 had their care plan updated to reflect having always more than one staff member in the room during care. The corrective action	

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F 609	Continued From page 2 diagnoses of Alzheimer's disease and dementia. R3's admission Minimum Data Set (MDS) assessment dated 11/1/22, indicated R3 had severely impaired cognition, clear speech, was able to understand and be understood. R3 required extensive assistance of one staff for most all activities of daily living. R3's care plan dated 11/2/22, indicated impaired cognitive function and impaired thought processes related to dementia; R3 would develop skills to cope with cognitive decline and maintain safety. R3's routine would be consistent to provide consistent care givers as much as possible in order to decrease confusion. During record review: --Progress note dated 1/9/23, at 9:37 p.m., documented by licensed practical nurse (LPN)-B read: while R3 was in the assisted dining room, R3 mouthed to a CNA and pointing at other staff, "watch out for him, he raped me." Reassured R3 she was safe and everyone here to help her. CNA reported R3 was fine after being reassured. Shortly after this conversation, approximately 30 minutes later, while with another CNA in R3's room, staff were helping R3 with PM (evening) cares. R3 stated to that CNA, "the black guy raped me, I don't want to go in that bed because he is in it." Again R3 was reassured everything was okay and was shown no one else was in her bed. R3 was good with explanation. --Progress note dated 1/10/23, 8:02 a.m., documented by social worker (SW) read: Spoke with R3 about this. R3 said the black man checked my pad, I didn't like it. It made me feel uncomfortable. I do not want black men touching me at all. Asked twice if this man hurt her and R3	F 609	regarding future alleged violations will be accomplished by educating staff regarding the significance of Abuse, Neglect, and Exploitation of company policies and procedures moving forward. A comprehensive internal investigation was completed addressing the potential allegations identified. All residents and staff were interviewed about potential knowledge of the abuse. R3 was put on 15-minute checks to monitor for social interactions. The facility identified that all residents were at risk of being impacted by this deficient practice and the failure to ensure residents ensure allegations of any type of abuse are reported to the State Agency (SA) in accordance with established policies and procedures. The measures that were put into place were system changes and processes to ensure staff is aware of how a resident□s alleged allegations of sexual abuse need to be immediately reported to the appropriate Charge Nurse, Director of Nursing, and Administrator. The State Survey Agency, Long Term Care Ombudsman, Adult Protective Services, and/or Law Enforcement immediately and in accordance with company policy but not later than after two hours of notification of the alleged allegation is reported to a staff member. The Long-Term Care Ombudsman will be on-site on 2/21/2023 at 2:00 pm to	

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F 609	Continued From page 3 said no, that the situation made her very uncomfortable. R3 was told she had the right to refuse care of anyone she chooses and that we would make sure he did not do her cares anymore. R3 was happy with this solution. During an interview on 1/18/23, at 11:03 a.m., nursing assistant (NA)-A stated on 1/17/23, she had heard from a coworker, (LPN)-A, that R3 said a male agency staff member had rubbed R3 when getting her cleaned up and NA-A should keep her ears open. During an interview on 1/18/23, at 11:14 a.m., R3 was sitting in a chair in her room and was asked if anyone had touched her inappropriately. R3 replied yes and took a folded piece of paper out of her pocket, asking, what do you make of this? The paper was a notification of an upcoming care conference. R3 was not able to say where she was or what day it was. R3 stated..."these men...they're horrible, some of them. I shouldn't say it, but he was black. There were two very bad ones." R3 stated she didn't tell anyone..."I didn't dare...I was too ashamed." When asked to describe what happened, R3 lifted her legs and put them straight out on the seat of the wheelchair directly in front of her. During an interview on 1/18/23, at 11:31 a.m., family member (FM)-C stated that on 1/11/23, at 6:53 p.m., R3 called her and was very upset. R3 told her...you have to come and help me...there is a guy here...he's going to rape me. FM-C reassured R3 she was safe, to which R3 replied, you don't believe me then. R3 described to FM-C a black man (later identified as NA-D) put his hands between her legs and rubbed her inner thighs and she had not been able to stop him.	F 609	educate staff on Trauma-Informed Care and Vulnerable Adult related education. The Trauma-Informed Care education was provided to staff to read and reflectively demonstrate knowledge via a quiz. Additional resources provided for easy reference are placed in the Nurse resource binder regarding the completion of internal incident management and reporting. A review of the Abuse, Neglect, and Misappropriation policy and procedure was reviewed by QAPI IDT Committee on January 24, 2023. A consistent review of reporting abuse, misappropriation, neglect, and resident rights will be identified at each during the resident council meeting. Alleged violations regarding allegations of sexual abuse are reported immediately, but not later than 2 hours after the allegation is made. The Administrator, Director of Nursing, and/or designees will report any potential or suspected abuse or any other defined abuse regardless of previous interactions, assessments, established BIMs, and/or related diagnosis to the State Agency, Adult Protective Services, and/or Law Enforcement immediately and in accordance with company policy. The facility will monitor its performance by completing weekly audits which include resident assessment observations and	

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F 609	Continued From page 4 FM-C stated she then telephoned the facility at about 7:00 p.m. and spoke to registered nurse (RN)-A and told her what R3 had said. RN-A told her NA-D had been in R3's room once and he seemed to be a trigger for her, so RN-A informed NA-D to work on the other end of the building. FM-C stated as a young girl, R3 had been raped by her father from age 9 to 13, and believed R3 was saying things related to that time of her life. During a telephone interview on 1/18/23, at 11:44 a.m. LPN-A stated she did not have any direct knowledge of an incident with R3 reporting alleged inappropriate touch, but rather, "Hearsay in the hall." LPN-A stated she spoke to R3 about it, possibly on 1/13/23, and had asked R3 if NA-D had used a washcloth to clean her, to which R3 replied, she guessed that's what NA-D had been doing. R3 described the NA-D to LPN-A as being a black male. LPN-A stated she heard the allegation had been reported to the director of nursing (DON) and the social worker (SW). During an interview on 1/18/23, at 11:56 a.m., both the director of nursing (DON) and social worker (SW) had been aware of R3's allegation of sexual abuse. The DON stated she had been informed of it on 1/9/23, at 9:00 p.m., when she received a telephone call from LPN-B who told her R3 had pointed at a black NA and said he raped her. The DON stated staff had identified this individual as NA-D, a new agency staff member, but he had not been assigned to R3's end of the hallway that evening. The DON stated she informed the SW of the allegation the following morning on 1/10/23, and asked the SW to speak to R3. According to the SW, when she spoke to R3, R3 used her hands to rub the insides of her thighs to show her what NA-D did.	F 609	Risk Management monitoring for three months or until substantial compliance is determined. Thereafter, the Director of Nursing, Social Services Director, and/or designee will maintain monthly audits regarding Reporting of Alleged Violations to the State Survey. The compliance audits will be reviewed and evaluated by the IDT at QAPI and QAA to determine appropriateness and effectiveness. Audit results will be reviewed at QAA to ensure that consistent substantial compliance has been achieved. The plan of correction was reported to the QAPI on 2/6/2023. The plan of correction will be reported to the QAA on 2/16/2023. The above corrective action measures will be completed on or before 2/21/2023.	

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F 609	Continued From page 5 The SW interviewed NA-D who said he had checked R3 to see if her pad was wet. The SW stated a report had not been made to the SA because her investigation concluded NA-D had just made R3 uncomfortable by checking her pad. The SW stated she thought they could investigate the allegation and if no concerns were identified, could resolve the issue without reporting to the SA. As a result, the DON and SW acknowledged that no further action had been taken by the facility: NA-D was allowed to continue to provide care to residents, residents were not interviewed to determine if they experienced similar behavior by staff, some staff were interviewed but no notes were taken, staff re-training had not been conducted, and R3's care plan had not been reviewed for potential changes. The DON and SW were not aware of R3's history of rape at a young age. In reviewing the facility policy titled Abuse, Neglect, and Exploitation, dated 8/2021, the SW stated allegations of abuse were to be reported to the SA within two hours and that an investigation should be conducted, including identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, and to provide complete and thorough documentation of the investigation. The DON and the SW acknowledged this had not been done. During a telephone interview on 1/18/23, at 1:05 p.m., LPN-B stated after two NA's informed her of allegations made by R3, she called the DON to report it and to ask what she should do. LPN-B stated the DON told her to document it and to tell both black, male agency nursing staff (an LPN and NA-D), not to be alone with R3. LPN-B stated she told the LPN, but NA-D was off duty by then.	F 609		

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F 609	Continued From page 6 LPN-B stated NA-D was never alone with R3 on that shift, but he also worked the night shift and would provide care to R3 in her room. During a telephone interview on 1/19/23, at 3:17 p.m. (from a return call from 1/18/23), NA-E stated that on 1/9/23, during the evening meal, she was in the dining room with R3. NA-D brought a resident in via wheelchair. R3 mouthed to NA-E, "watch out for him." When NA-E asked why, R3 mouthed the words "he raped me." NA-E reassured R3 she was safe. Once R3 was done with her meal and NA-E had a moment, she informed LPN-B at approximately 7:30 p.m. what R3 told her in the dining room. During a telephone interview on 1/18/23, at 1:13 p.m., NA-C stated R3 told her directly on 1/9/23, as she was preparing R3 for bed, that she had been raped by a black man. NA-C reported this right away to LPN-B, and stated NA-D had not been around R3 on that shift. During an interview on 1/18/23, at 2:38 p.m., NA-D recounted that on 1/6/23, at 2:00 a.m., he went to R3's room and turned on the light to check her. NA-D stated that had been his second day at the facility, and the first time R3 had seen him. NA-D stated R3 immediately stated yelling, so he turned off the light, and got a nurse. NA-D stated he had not provided care to R3 nor had he checked her brief. NA-D could not recall the name of the nurse he spoke to. During an interview on 1/18/23, at 9:45 a.m., the administrator stated there were no reports of sexual abuse at the facility in the last several months. During an interview on 1/18/23, at 2:45 p.m., the DON stated she could not recall if she	F 609		

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F 609	Continued From page 7 informed the administrator of R3's allegation of abuse. Facility policy titled Abuse, Neglect, and Exploitation, dated 8/2021, indicated an immediate investigation was warranted when suspicion of abuse occurred. The facility would ensure all residents were protected from physical and psychosocial harm during and after the investigation. The facility would report all alleged violations to the administrator, or designee, state agency, and any other required agencies within specified timeframes: immediately, but not later than two hours after the allegation is made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 610	F610- Investigate/Prevent/Correct	2/21/23

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	245436	A. BUILDING _____ B. WING _____	C 01/18/2023

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

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F 610	Continued From page 8 facility failed to ensure an investigation and protections were initiated, for 1 of 1 resident (R3) who reported to staff an allegation of staff to resident sexual abuse. Findings include: R3's facesheet printed on 1/18/23, included diagnoses of Alzheimer's disease and dementia. R3's admission Minimum Data Set (MDS) assessment dated 11/1/22, indicated R3 had severely impaired cognition, clear speech, was able to understand and be understood. R3 required extensive assistance of one staff for all activities of daily living except eating. R3's care plan dated 11/2/22, indicated impaired cognitive function and impaired thought processes related to dementia; R3 would develop skills to cope with cognitive decline and maintain safety. R3's routine would be consistent to provide consistent care givers as much as possible in order to decrease confusion. During record review: --Progress note dated 1/9/23, at 9:37 p.m., documented by licensed practical nurse (LPN)-B read: while R3 was in the assisted dining room R3 mouthed to a CNA and pointing at other staff, "watch out for him, he raped me." Reassured R3 she was safe and everyone here to help her. CNA reported R3 was fine after being reassured. Shortly after this conversation, approximately 30 minutes later, while with another CNA in R3's room, staff were helping R3 with PM (evening) cares. R3 stated to that CNA, "the black guy raped me, I don't want to go in that bed because he is in it." Again R3 was reassured everything	F 610	Alleged Violation It is the facility's intent to comply with the regulation to Investigate/Prevent/Correct Alleged Violations, and to investigate and/or report timely to the State Agency (SA) regarding potential allegations of sexual abuse. The corrective action taken for R3 will have two staff members assist the resident while completing cares. When conflict arises, remove residents to a calm safe environment and allow them to vent/share feelings. The care plan was modified to identify this increased need for communication between the resident, family, and caregivers regarding care, and living environment, explaining all available procedures, treatments, medications, results of labs/tests, conditions, all changes, rules, and options. The facility's Interdisciplinary Team consulted with the POA and family members regarding the availability of off-site or telehealth emotional, behavioral, and/or mental health resources. R3 was put on 15-minute checks to monitor for social interactions. The corrective action regarding future alleged violations will be accomplished by educating staff regarding the significance of Abuse, Neglect, and Exploitation of company policies and procedures moving forward. A comprehensive internal investigation was completed addressing the potential allegation identified.	

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F 610	Continued From page 9 was okay and was shown no one else was in her bed. R3 was good with explanation. --Progress note dated 1/10/23, 8:02 a.m., documented by social worker (SW) read: Spoke with R3 about this. R3 said the black man checked my pad, I didn't like it. It made me feel uncomfortable. I do not want black men touching me at all. Asked twice if this man hurt her and R3 said no, that the situation made her very uncomfortable. R3 was told she had the right to refuse care of anyone she chooses and that we would make sure he did not do her cares anymore. R3 was happy with this solution. During an interview on 1/18/23, at 11:14 a.m., R3 was sitting in a chair in her room and was asked if anyone had touched her inappropriately. R3 replied yes and took a folded piece of paper out of her pocket, stating, what do you make of this? The paper was a notification of an upcoming care conference. R3 was not able to say where she was or what day it was. R3 stated..."these men...they're horrible, some of them. I shouldn't say it, but he was black. There were two very bad ones." R3 stated she didn't tell anyone..."I didn't dare...I was too ashamed." When asked to describe what happened, R3 lifted her legs and put them straight out on the seat of the adjacent wheelchair. During an interview on 1/18/23, at 11:56 a.m., both the director of nursing (DON) and social worker (SW) had been aware of R3's allegation of sexual abuse. The SW stated her investigation consisted of speaking to the resident, nursing assistant (NA)-D, and some staff. A comprehensive investigation to ensure the ongoing safety of all residents had not been conducted, such as interviews with staff,	F 610	The facility identified that all residents were at risk of being impacted by this deficient practice and the failure to ensure residents alleged allegations of sexual abuse are investigated and reported in a timely manner according to company policy and regulation. The measures that were put into place were education provided to direct and indirect care licensed staff regarding the investigation and reporting procedures. Unlicensed assistive personnel will be provided education on the reporting and investigation process. Additional resources provided for easy reference are placed in the Nurse resource binder regarding the completion of internal incident management and reporting. Policies and Procedures reviewed reflecting appropriate practices. The Long-Term Care Ombudsman will be on-site on 2/21/2023 at 2:00 pm to educate staff on Trauma-Informed Care and Vulnerable Adult related education. The Trauma-Informed Care education was provided to staff to read and reflectively demonstrate knowledge via a quiz. All outstanding Risk Management incidents have been reviewed and followed up on with care plan revisions that were modified as needed after investigation. The Administrator, Social Services Director, and/or designee will update and maintain Grievance/Reportable Events	

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F 610	Continued From page 10 residents and R3's family. In addition, no notes had been taken other than one progress note after speaking to R3. Furthermore, the DON and SW acknowledged NA-D was allowed to continue to provide care to residents; staff re-training had not been conducted, and R3's care plan had not been reviewed for potential changes. In reviewing the facility policy titled Abuse, Neglect, and Exploitation, dated 8/2021, the SW stated an investigation should be conducted, including identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; and to provide complete and thorough documentation of the investigation. The DON and the SW acknowledged this had not been done. Facility policy titled Abuse, Neglect, and Exploitation, dated 8/2021, indicated an immediate investigation was warranted when suspicion of abuse occurred. The facility would ensure all residents were protected from physical and psychosocial harm during and after the investigation. An investigation would be conducted, including identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; and to provide complete and thorough documentation of the investigation.	F 610	Log to ensure that the facility appropriately responds to and investigates allegations of abuse. The reported incidents will be placed in PointClickCare under the Risk Management tab. The Director of Nursing and Administrator will continue to review all incidents, investigations, and corrective actions in PointClickCare Risk Management. Those incidents will be reviewed at the QAPI weekly meetings by the IDT team to observe trends and verify appropriate investigations occur and/or follow up as needed. The facility will monitor by completing the following audits-The DON or designee, will conduct a random audit of 5 residents weekly x 4 consecutive weeks. These residents will be assessed and interviewed to ensure that any allegations of potential abuse are identified, properly investigated, and reported to the appropriate people and/or State Agency. After the initial audits are completed quarterly x 2, or until substantial compliance is determined. Audit results will be reviewed at QAA to ensure that consistent substantial compliance has been achieved. The plan of correction was reported to the QAPI on 2/6/2023. The plan of correction will be reported to the QAA on 2/16/2023. The above corrective action measures will	

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F 610	Continued From page 11	F 610	be completed on or before 2/21/2023.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 31, 2023

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

Re: Event ID: YMG411

Dear Administrator:

The above facility survey was completed on January 18, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 1/18/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54367715C (MN83958)), however NO licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H54367397C (MN89938 and MN89960), H54367616C (MN90147). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		