Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 12, 2026

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

RE: CCN: 245436
Cycle Start Date: April 7, 2026

Dear Administrator:

On June 9, 2026, 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.

Sincerely,

Sarah Lane

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

Email: sarah.lane@state.mn.us

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June 12, 2026

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

Re: Reinspection Results
Event ID: 22CA1C-H2

Dear Administrator:

On June 9, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 7, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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An equal opportunity employer.

DEPARTMENT OF HEALTH

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April 29, 2026

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

RE: CCN:245436
Cycle Start Date: April 7, 2026

Dear Administrator:

On April 7, 2026, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 July 7, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 7, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have

one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

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April 29, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 22CA1C-H1

Dear Administrator:

The above facility survey was completed on April 7, 2026, 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 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 only a suggestion 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.

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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 4/2/26, 4/3/26, and 4/7/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54369780C (2967413) with deficiencies issued at F568, F580, F657 and F689 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.	F0000		05/27/2026
F0568 SS = E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is NOT MET as evidenced by:	F0568	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who drafted or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. F0568 – Accounting and Records of Personal Funds Policy Statement It is the policy of Parkview Care Center to comply with all state and federal regulations, including F0568: Accounting and Records of Personal Funds, to ensure the health, safety, and welfare of all residents. The facility is committed to maintaining	05/27/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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

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F0568 SS = E	Continued from page 1 The facility failed to maintain complete and accurate accounting records of resident personal funds for 10 of 10 residents (R17, R18, R19, R20, R21, R22, R23, R12, R9, R11) whose funds were maintained in a commingled facility trust account. Findings include: The facility provided resident trust statements for all the residents who had given the facility to manage. The trust statements only had the balance with no accounting of credits or debits from the account. Further the trust statements did not identify and/or account for interest earned if any. R17's trust statement dated 4/3/26, identified a balance of $94.73. R18's trust statement dated 4/3/26, identified a balance of $85.00. R19's trust statement dated 4/3/26, identified a balance of $1,899.11. R20's trust statement dated 4/3/26, identified a balance of $100.00. R21's trust statement dated 4/3/26, identified a balance of $349.00. R22's trust statement dated 4/3/26, identified a balance of $100.00. R23's trust statement dated 4/3/26, identified a balance of ($15.00). This indicated the balance was negative. R12's trust statement dated 4/3/26, identified a balance of $45.00. R9's trust statement dated 4/3/26, identified a balance of $77.00. R11's trust statement dated 4/3/26, identified a balance of $58.00. The facility checking account statement ending 1/30/26, identified a beginning balance on 1/1/26, of $5,315.53 and ending balance of $5,125.53. On 1/2/26, a deposit was made under R17's name. The statement did not account for any other resident debits or credits. The facility checking account statement ending 2/27/26, identified a beginning balance on 1/31/26,	F0568	Continued from page 1 complete and accurate accounting records for all resident personal funds, including those maintained in a commingled facility trust account. Corrective Actions for Residents Affected by the Deficient Practice The following corrective actions will be taken for residents directly affected (R17, R18, R19, R20, R21, R22, R23, R12, R9, R11): Immediate Audit and Reconciliation: A full audit and reconciliation of the resident trust account funds in both the checking and interest-bearing resident trust savings account required for the 10 identified residents was conducted by the Corporate Account Receivable Director, as identified by the deficiency. The Resident Trust Account Manager from the sister facility reviewed the current practices and the PointClickCare resident trust account activity to determine the process issues that contributed to the resident trust account discrepancies. Any discrepancies were corrected, and residents and/or their responsible parties were notified, and any corrective actions were taken. Resident Notification: Each affected resident and/or their responsible party received a letter regarding the Resident Trust Account process moving forward, and a summary of interest accrued was presented to the resident and/or responsible party. Restitution: If any resident was found to have a discrepancy resulting in a financial loss, immediate restitution was made to the resident's account. Actions to Identify Other Potentially Affected Residents Comprehensive Review: A comprehensive review of all resident personal trust fund accounts will be conducted to identify any additional residents potentially affected by incomplete or inaccurate accounting records.	05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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F0568 SS = E	Continued from page 2 of $5,125.53 and ending balance of 5028.96. On 2/3/26, a deposit was made under R17's name for $1,145.00. The statement did not account for any other resident debits or credits. The facility checking account statement ending 3/31/26, identified a beginning balance on 2/28/26, of $5,028.96 and ending balance of 4700.02. On 3/3/26, a deposit for $1,145.00 was made under R17's name. The statement did not account for any other resident debits or credits. The facility Business Savings account statement ending 12/31/25, identified a balance of $401.53. Interest earned from 10/1/25-12/31/25 was $0.05 with a year-to-date interest balance of $0.20. The facility Business Savings account statement ending 3/31/26, identified a balance of $401.53. Interest earned was $0.05, bringing the balance to $401.58. During an interview on 4/2/26 at 3:14 p.m., activity director (AD)-A stated she manages the funds for seven residents. AD-A does not have access to the account and it is a non-interest bearing account. AD-A manages the accounts by paying for items monthly for residents such as haircuts. AD-A pays the hairdresser with checks she has and then gives them to the Administrator. Within the electronic record facility there is an area to record deposits and withdrawals. AD-A was unaware how to record this information, so the information does not match the actual bank statements. AD-A prints off the balances from the electronic record and mails them to families every three months. During an interview on 4/7/26 at 10:28 a.m., Administrator stated the business office (BO)-A at a sister facility managed the trust accounts. BO-A deposits the money in savings and when funds are needed transferred them to checking. Administrator acknowledged the bank statements identified R17 was the only resident represented on the bank statement. Administrator acknowledged the facility needed education on how to track and deposit resident funds with a ledger which identified each individual residents expenditures.	F0568	Continued from page 2 Audit Process: The review included: A full audit of all resident trust accounts and interest accruals past balance owed was completed by the corporate accounts receivable director. Resident/Responsible Party Notification: All residents and/or their responsible parties were notified of their current account balances and provided with a summary of transactions. An informational letter to the resident representative, or power of attorney, identifying the importance of keeping the resident's trust account positive, will be sent out in the monthly billing statements by the sister facility's Resident Trust Account Manager. Measures to Ensure the Deficient Practice Does Not Recur Staff Education and Training: The on-site Resident Trust Account Manager responsible for handling resident funds received in-service training on F0568 requirements and facility policies regarding resident personal funds on 5/5/2026 by the sister facilities' resident trust account manager. Training will include proper documentation, reconciliation procedures, and resident rights regarding personal funds. Training was also provided by the sister facility resident trust account manager to the on-site resident trust account manager regarding the following: How to do a monthly withdrawal and a monthly deposit in PointClickCare. Not to post all transactions individually, but to enter transactions from the month and then post them in PointClickCare. Education on the resident trust account spreadsheet and how to use it. Importance of how no resident's trust account can be in the negative.	05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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F0568 SS = E		F0568	Continued from page 3 Family needs to be contacted immediately regarding low balances. A signature is required by a resident or family member to verify deposits and withdrawals. If a check is provided, then no signature is required. Policy and Procedure Review: Facility policies and procedures for managing resident personal funds will be reviewed and revised as necessary to ensure compliance with F0568 and best practices. Updated policies will include step-by-step procedures for maintaining accurate records, conducting monthly reconciliations, and providing regular statements to residents. Ongoing Reminders and Resources: The on-site Resident Trust Account Manager or designee will have access to updated forms and checklists to ensure compliance. Monitoring to Ensure Effective Implementation of Actions Ongoing Audits: The on-site Resident Trust Account Manager or designee will conduct monthly audits of all resident personal fund accounts for the next three months, then quarterly thereafter. Any issues found during the audit results will be brought to the immediate attention of the Administrator or Assistant Administrator to provide reconciliation of the resident trust fund account. QAPI Review: Audit results will be reviewed at the monthly QAPI (Quality Assurance and Performance Improvement) committee meetings. The QAPI committee will assess audit outcomes and determine if further monitoring or corrective actions are needed.	05/27/2026

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F0568 SS = E		F0568	Continued from page 4 The audit results will be reported at the quarterly QAA meeting. Continuous Improvement: Any identified issues will be addressed immediately, and additional staff training will be provided as needed. Person Responsible to Maintain Compliance The on-site Resident Trust Account Manager or designee will oversee the implementation and ongoing compliance efforts related to this Plan of Correction, with oversight from the Administrator or Assistant Administrator. Completion Date May 27, 2026	05/27/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is	F0580	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who drafted or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. F0580 – Notify of Changes (Injury/Decline/Room, etc.) The facility failed to notify the physician of recurrent refusals of physician-ordered medication for 1 of 1 residents (R21)who required lactulose for treatment and management of constipation and hepatic failure/alcoholic cirrhosis. Policy Statement It is the policy of Parkview Care Center to comply with all state and federal regulations, including F0580, to ensure the health, safety, and welfare of all residents. The facility will promptly notify the resident’s physician when there is a significant change in the resident’s condition, including recurrent refusals of physician-ordered medications, to ensure appropriate clinical interventions and continuity of care.	05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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PARKVIEW CARE CENTER	55 TENTH STREET SOUTHEAST , WELLS, Minnesota, 56097

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F0580 SS = D	Continued from page 5 available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to notify the physician of recurrent refusals of physician ordered medication for 1 of 1 residents (R21) who required lactulose for treatment and management of constipation and hepatic failure/alcoholic cirrhosis. Findings include R21's face sheet dated 4/3/26, identified diagnoses of chronic hepatic failure without coma, and alcoholic cirrhosis of liver without ascites. R21's quarterly Minimum Data Set (MDS) dated 3/4/26, identified R21 had no cognitive impairment. R21 rejected cares 1-3 days. R21's care plan dated 9/4/25, identified R12 had diagnoses of constipation and is at risk for constipation when refuses medication for constipation, is receiving laxatives-Lactulose and MiraLAX for management related to diagnoses of	F0580	Continued from page 5 Corrective Actions for Residents Affected by the Deficient Practice Resident(R21): R21's care plan was reviewed and revised to include hepatic failure/cirrhosis, proper physician and family notifications, and refusal of medications, specifically lactulose. TMA-A was reeducated on the importance and purpose of lactulose and where to find information on medication orders. LPN-A was reeducated on knowing the purpose of R21 prescribing of lactulose, not only for constipation but also for hepatic failure. LPN-B was reeducated on the risks associated with the diagnosis of hepatic failure/cirrhosis and identifying appropriate associated monitoring for signs and symptoms of worsening hepatic failure. Associated monitoring for signs and symptoms of worsening condition of hepatic failure/alcoholic cirrhosis was added to R21's eMAR orders. Licensed nursing staff were reeducated to make progress notes for medication refusals, monitor for constipation and treat according to protocol and orders, monitor for signs of worsening hepatic failure with proper notifications to the DON, provider, and family contact. There had been several notifications to the provider regarding R21's medication refusals, as well as documented Provider Visit Progress Notes noting R21's refusals and a suggestion to offer hospice if he wishes to continue to refuse medications. UHD Hospice did an evaluation, and he does not meet the criteria at this time. Actions to Identify Other Potentially Affected Residents A comprehensive review of all current residents' medication administration records (MARs) for the past 60 days will be conducted to identify any other residents with recurrent refusals of physician-ordered medications. The review will include: Audit of eMARs for documentation of medication refusals.	05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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

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F0580 SS = D	Continued from page 6 cirrhosis of liver. Will refuse other medications for bowels. Interventions included administer medications as ordered. Document if he refuses. Encourage R21 to sit on toilet to evacuate bowels if possible. Follow facility protocol for bowel management. Document if R21 refuses to follow protocol to help evacuate bowels. R21's care plan dated 1/26/26, identified R21 can be resistive to cares. Often refuses medications and hygiene. Interventions included to allow R21 to make reasonable decisions about treatment regime to provide sense of control. R21's physician orders signed 3/19/26, identified an order for Lactulose. Give 45 milliliters (ml) by mouth three times a day related to hepatic failure. R21's medication administration record (MAR) dated 3/2026, identified Lactulose scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m. All administrations reviewed from 3/1/26-3/31/26, identified R21 was administered only 19 doses of the physician ordered lactulose of 93 doses that were ordered. R21's Provider Notification Form dated 3/18/26, identified R21 continued to refuse medications. Medical doctor (MD)-A replied he would address on nursing home rounds. R21's physician visit note dated 3/19/26, did not identify or address R21's medication refusals as per the provider notification. R21's MAR dated 4/2026, identified Lactulose scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m. All administrations reviewed from 4/1/26-4/7/26 at 8:00 a.m., were signed with a "2", which indicated drug refused. Review of R21's progress notes for 4/2026, did not identify and/or address R21's lactulose refusals nor evident physician was notified of R21's refusals. During an interview on 4/3/26 at 1:21 p.m., trained medication aide (TMA)-A stated if a resident refused a medication, the nurse needed to be notified right away. TMA-A was unable to articulate why R21 took Lactulose and what staff should monitor for when he refused it. During an interview on 4/3/26 at 1:39 p.m., licensed practical nurse (LPN)-A stated R21 took Lactulose for chronic constipation. R21 would refuse a lot and would need coaxing to take medication. If medications were refused for three days the doctor	F0580	Continued from page 6 Review of care plans to confirm that refusals and physician notifications are accurately reflected. Any additional residents identified will have their physicians and family contacts notified, and their care plans updated accordingly. Measures to Ensure the Deficient Practice Does Not Recur Staff Education and Training: All licensed nursing staff will receive in-service training on the facility's "Notification of Changes" policy for physician notification, with emphasis on the requirement to notify the physician, family contact, and DON of recurrent medication refusals and worsening of conditions, and to document such notifications in the progress note of the resident's chart. This training will also include R21 with specific education regarding hepatic failure, symptoms, and lactulose refusals. Policy and Procedure Review: The facility's Notification of Changes policy was reviewed and revised as necessary to clarify expectations regarding medication refusals and physician notification. Monitoring to Ensure Effective Implementation of Actions The Director of Nursing (DON) or designee will audit R21's eMAR and 3 random resident eMARs weekly for one month, then R21's eMAR and 1 random resident weekly thereafter for 2 months to ensure that all recurrent medication refusals are followed by timely physician notification and proper documentation. Audit results will be reviewed during the weekly QAPI committee meetings. The QAPI committee will assess audit outcomes and determine if further monitoring, education, or policy revisions are required. Audit results will be presented at the quarterly QAA meeting.	05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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F0580 SS = D	Continued from page 7 should be notified. LPN-B could not find anything in R21's care plan for the management of hepatic failure/cirrhosis aside from bowel management and was unable to articulate R21's risks associated with the diagnosis of hepatic failure/cirrhosis and unable to identify appropriate associated monitoring systems for sign/symptoms of worsening condition. During an interview on 4/3/26 at 3:03 p.m., registered nurse (RN)-B stated R21 took Lactulose for an alcoholic liver. R21 refused medications often. Physician should be notified right away of refusal of medications through the Physician Notification Form; education and explanation of the need to take medication should be provided to R21, along with writing a progress note. During an interview on 4/7/26 at 9:36 a.m., director of nursing (DON) was unaware if staff had been documenting refusals of medications in the progress notes recently but knew it had been done in the past. DON did not realize R21 did not have a care plan regarding cirrhosis of liver. The facility Notification of Changes policy revised 12/2025, identified the facility promptly informs the resident, consults the residents physician, and notifies, consistent with his or her authority, the residents representative when there is a change requiring notification. The facility abuse policy was requested on 4/2/26 at 3:02 p.m. but not received.	F0580	Continued from page 7 Continuous Improvement: Any identified issues will be addressed immediately, and additional staff training and corrective action will be provided as needed. Person Responsible to Maintain Compliance The Director of Nursing, Administrator, and Assistant Administrator will oversee the implementation and ongoing compliance efforts related to this Plan of Correction. Completion Date May 27, 2026	05/27/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F0657	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who drafted or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. F0657 – Care Plan Timing and Revision The facility failed to revise behavioral care plans after a resident-to-resident altercation for 1 of 1 residents (R11) reviewed for abuse. In addition, the facility failed to revise the care plan to reflect the ongoing pattern of medication refusals for 1 of 1 resident (R21) who was prescribed a clinically significant medication used to treat a diagnosis of cirrhosis/hepatic failure.	05/27/2026

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F0657 SS = D	Continued from page 8 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to revise behavioral care plan after resident-to-resident altercation for 1 of 1 resident (R11) reviewed for abuse. In addition, the facility failed to revise the care plan to reflect ongoing pattern of medication refusals for 1 of 1 resident (R21) who was prescribed a clinically significant medication used to treat a diagnosis of cirrhosis/hepatic failure. Findings include: R11’s face sheet dated 4/2/26, identified diagnoses of Alzheimer’s disease with late onset, anxiety disorder, mild cognitive impairment, and blindness of right eye. R11’s physician order dated 6/12/24, identified to monitor and note behavior in progress note of irritability, verbal aggression, stating he feels down or blue, not visiting with others, walking the halls, and not eating. R11’s physician order dated 6/8/25, identified to check R11’s room daily for weapons such as scissors, knives, forks, etc. after recent episodes of aggression. R11’s quarterly Minimum Data Set (MDS) dated 1/21/26, identified R1 had some difficulty with hearing and speech clarity. R11 was rarely understood and had severe cognitive impairment. R11 had inattention and disorganized thinking. R11 had behavioral problems which included physical behavioral symptoms directed towards others and verbal behavioral symptoms directed towards others. R11 rejected care and wandered 1-3 days. R11 was independent with a wheelchair.	F0657	Continued from page 8 Policy Statement It is the policy of Parkview Care Center to comply with all state and federal regulations, including F0657, to ensure the health, safety, and welfare of all residents. The facility is committed to timely and accurate revision of care plans to reflect changes in residents’ needs, behaviors, and responses to interventions. Corrective Actions for Residents Affected by the Deficient Practice Resident R11: The care plan for R11 was reviewed and revised to address the effectiveness of behavioral interventions regarding the resident-to-resident altercation that had been added to the care plan and to identify a need for new interventions after new aggression toward another resident and staff. Interventions were updated to include specific strategies for preventing future altercations and increased monitoring. The interdisciplinary team, including his county care coordinator, nursing, social services, dietary, and activities, met for a scheduled care conference with R11 and their representative to discuss the updated care plan and ensure understanding and agreement of interventions. The sister facility Social Service Director has been working with the Faribault County Care Coordinator, the resident’s wife, and the Ombudsman due to increased behaviors to find a more appropriate setting for R11. Resident R21: The care plan for R21 was reviewed and revised to reflect the ongoing pattern of medication refusals, specifically for the clinically significant medication prescribed for cirrhosis/hepatic failure and associated risks. Hepatic failure/cirrhosis problem was added to the care plan with interventions to monitor for worsening symptoms and need for appropriate notifications. Interventions include documentation of refusal patterns, resident education regarding medication	05/27/2026

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F0657 SS = D	Continued from page 9 R11's care plan dated identified, R11 exhibited a behavior of inappropriate touching of females dated 5/28/24 with associated interventions that included administer medication as ordered; caregivers provide opportunity for positive interaction and attention; Stop and talk to R11 when passing by; Intervene as necessary to protect the rights and safety of others; Approach/speak in a calm manner. Divert attention; Remove from situation and take to alternate location as needed; Monitor behavior episodes and attempt to determine underlying cause; Monitor R11's whereabouts when his room entry motion sensor alarm goes off to see if his is leaving his room to monitor where he is going; Social service designee will discuss behavior with resident and explain/reinforce why it is inappropriate and/or unacceptable to touch other residents, especially females inappropriately one day every week. R11's care plan dated 6/1/25, identified R11 had incidents of verbal aggression with resident 1120. R11 had been asked to move tables in the dining room and refused. R11 and resident 1120 get along much of the time. Interventions included analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Do not wake R11 when sleeping as this can agitate him. Monitor/document/report as needed any signs/symptoms of R11 posing danger to himself and others. Staff to monitor R11's whereabouts and what he is doing when out of his room and around resident 1120. If able, try and get R11 to leave situation. If it is mealtime, tell R11 he can come back in a little while. R11's progress note dated 12/29/25 at 10:26 a.m., identified R11 had been agitated all day. At 8:30 a.m., R11 was outside of his room, in hallway and another resident walked by. R11 swung at the other resident. The other resident ducked. R11 did not make contact with his fist on the other resident. Staff members observed and went to residents. Went to R11's room and he pointed at his bed which appeared wet. Wondered if R11 thought the other resident had wet his bed. The other resident appeared frightened. It was also reported that when nursing staff was assisting R11 to the breakfast table, he hit out at another resident sitting next to him but did not make contact. Later in the morning, the other resident that R11 had previously struck out at, was in the dining room. R11 went up to the resident and was mumbling in anger. The other resident was frightened and put his arms up and walked away from R11 to the other side of the dining	F0657	Continued from page 9 benefits/risks, related symptoms, and engagement of the physician and pharmacist for alternative strategies. The resident and their representative were informed of the updated care plan and provided with education on the importance of medication adherence, specifically his lactulose. Provider reviewed labs, specific for liver enzymes and function, and determined they were stable. Nursing staff, including LPNs, RNs, and TMAs, were reeducated as to why R21 receives lactulose and what they should monitor for when he refuses it. Nursing staff were educated on the updated Care plan interventions for R11 and R21. An All-Staff meeting will be held on May 13, 2026, at 2 PM and will cover, but not be limited to, behavioral topics and interventions, including but not limited to resident-to-resident altercations and resident-to-staff altercations, and dementia. DON received reeducation from corporate nurse consultants on 5/7/2026, including the need to revise care plans with appropriate interventions after identifying aggressive/agitated behaviors, resident-to-resident and/or resident-to-staff altercations. Actions to Identify Other Potentially Affected Residents It was determined that all residents had the potential to be affected by this deficient practice. A comprehensive review of all current residents' care plans will be conducted to identify any other individuals with: Recent behavioral incidents (e.g., altercations, aggression) have not been reflected in their care plans. Patterns of medication refusals, especially for clinically significant medications, are not addressed in their care plans. This review will include: Audit of all resident charts for the past 60 days for	05/27/2026

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F0657 SS = D	Continued from page 10 room without his walker because R11 was close to the walker. Staff intervened and got the other resident his walker. In review of R11's record it was not evident care plan interventions were evaluated for effectiveness after the incident and R11's care plan did not identify the new aggression toward another resident and staff nor new interventions to manage the behaviors R11 displayed on 12/29/25. During an observation on 4/2/26 at 1:19 p.m., R11 was in his room. R11's room was located on the opposite side of facility as R12. During an interview on 4/2/26 at 1:20 p.m., nursing assistant (NA)-D stated R11 was both aggressive and not aggressive depending on time of day and approach. NA-D had never seen R11 aggressive towards residents, only staff. R11 would kick and hit at staff. NA-D tried to maintain a healthy distance away from R11 if R11 was being aggressive. NA-D would allow R11 to calm down before reapproaching for cares if he was aggressive. NA-D was unaware of incident between R11 and R12 in December. During an interview on 4/2/26 at 1:25 p.m., NA-B stated R11 could be aggressive but had never witnessed aggression towards other residents. R11 would show aggression to staff if NA's woke him up before he wanted to get up, when that would happen it would affect R11's whole day. R11 would be upset and chase the NA's around the facility. R11's Kardex identified to intervene as necessary, to protect and approach in calm manor, remove from situation, and take to an alternate location as needed. NA-B stated she would intervene before R11's agitation escalated, engage calmly in conversation and approach later if needed. During an interview on 4/7/26 at 9:36 a.m., director of nursing (DON) stated after the incident on 12/29/25, R11 and R12 were separated from each other and asked to stay away from each other as much as possible. DON did not revise R11's care plan interventions after the altercation to identify aggressive/agitative behaviors toward R12 and staff. Root cause of incident was that R11 did not know or realize what he was doing. R21's face sheet dated 4/3/26, identified diagnoses of chronic hepatic failure without coma, and alcoholic cirrhosis of liver without ascites. R21's care plan dated 9/4/25, identified R12 had	F0657	Continued from page 10 documentation of behavioral incidents and/or medication refusals. This will include a cross-reference with incident reports, electronic medication administration records (eMARs), and progress notes. Immediate revision of any care plans will be completed if any records are found to be deficient. An All-Staff meeting will be held on May 13, 2026, at 2 PM and will cover, but not be limited to, behavioral topics and interventions, including but not limited to resident-to-resident altercations and resident-to-staff altercations, and dementia. DON received reeducation from corporate nurse consultants on 5/7/2026 to revise care plans with appropriate interventions after identifying aggressive/agitated behaviors, resident-to-resident and/or resident-to-staff altercations. Measures to Ensure the Deficient Practice Does Not Recur Staff Education and Training: All licensed nursing staff, including the DON, will receive in-service training on care plan revision requirements, including timely updates after behavioral incidents and medication refusals. An All-Staff meeting will be held on May 13, 2026, at 2 PM and will cover, but not be limited to, behavioral topics and interventions, including but not limited to resident-to-resident altercations and resident-to-staff altercations, and dementia. DON received reeducation from corporate nurse consultants on 5/7/2026 to revise care plans with appropriate interventions after identifying aggressive/agitated behaviors, resident-to-resident and/or resident-to-staff altercations. Policy and Procedure Review: The facility's care planning policy will be reviewed and revised as necessary to ensure alignment with F0657 and best practices for timely care plan updates. Monitoring to Ensure Effective Implementation of Actions The Director of Nursing (DON) or designee will audit	05/27/2026

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F0657 SS = D	Continued from page 11 diagnoses of constipation and is at risk for constipation when refuses medication for constipation, is receiving laxatives-Lactulose and MiraLAX for management related to diagnoses of cirrhosis of liver. Will refuse other medications for bowels. Interventions included administer medications as ordered. Document if he refuses. Encourage R21 to sit on toilet to evacuate bowels if possible. Follow facility protocol for bowel management. Document if R21 refuses to follow protocol to help evacuate bowels. Provide pericare after each incontinent episode. R21's care plan dated 1/26/26, identified R21 can be resistive to cares. Often refuses medications and hygiene. Interventions included to allow R21 to make reasonable decisions about treatment regime to provide sense of control. R21's quarterly MDS dated 3/4/26, identified R21 had no cognitive impairment. R21 rejected cares 1-3 days. R21's physician orders signed 3/19/26, identified an order for Lactulose. Give 45 milliliters (ml) by mouth three times a day related to hepatic failure. R21's medication administration record (MAR) dated 3/2026, identified Lactulose scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m. All administrations reviewed from 3/1/26-3/31/26, with only 19/93 administrations administered. R21's Provider Notification Form dated 3/18/26, identified R21 continued to refuse medications. Medical doctor (MD)-A replied he would address on nursing home rounds. R21's physician visit note dated 3/19/26, did not address the medication refusals as indicated by the physician notification form dated 3/18/26. R21's MAR dated 4/2026, identified Lactulose order which was scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m.; 19 of possible 19 administrations reviewed from 4/1/26 through 4/7/26 at 8:00 a.m., were signed with a "2", which indicated drug refused. Review of R21's progress notes between 4/1/26 through 4/7/26 did not include follow-up and/or address R21's refusals of Lactulose. R21's record reviewed between 3/4/26 through 4/7/6 revealed even though R21 had ongoing refusals of lactulose (74 doses) according to March	F0657	Continued from page 11 3 random resident care plans weekly for one month, then 1 random resident care plan weekly thereafter for 2 months to ensure that all behavioral incidents and medication refusals are promptly reflected in care plan revisions. Audit results will be reviewed during the weekly QAPI committee meetings. The QAPI committee will assess audit outcomes and determine if further monitoring, education, or policy revisions are required. Audit results will be presented at the quarterly QAA meeting. Continuous Improvement: Any identified issues will be addressed immediately, and additional staff training or corrective action will be provided as needed. Person Responsible to Maintain Compliance The Director of Nursing, Administrator, and Assistant Administrator will oversee the implementation and ongoing compliance efforts related to this Plan of Correction. Completion Date: May 27, 2026	05/27/2026

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F0657 SS = D	Continued from page 12 2026 MAR, April MAR and R21's Provider Notification Form dated 3/18/26, that identified R21 continued to refuse medications there was no indication the care plan for refusals was reviewed and evaluated for effectiveness and updated to address R21's treatment needs, associated risks (i.e.- encephalopathy), patterns of the refusals and individualized interventions to manage the behavior. During an interview on 4/3/26 at 1:21 p.m., trained medication aide (TMA)-A stated if a resident refused a medication, the nurse needed to be notified right away. TMA-A was unable to articulate why R21 took Lactulose and what staff should monitor for when he refused it. During an interview on 4/3/26 at 1:39 p.m., licensed practical nurse (LPN)-A stated R21 took Lactulose for chronic constipation. R21 would refuse a lot and would need coaxing to take medication. If medications were refused for three days the doctor should be notified. LPN-B could not find anything in R21's care plan for the management of hepatic failure/cirrhosis aside from bowel management and was unable to articulate R21's risks associated with the diagnosis of hepatic failure/cirrhosis and unable to identify appropriate associated monitoring systems for sign/symptoms of worsening condition. During an interview on 4/3/26 at 3:03 p.m., registered nurse (RN)-B stated R21 took Lactulose for an alcoholic liver. R21 refused medications often. Education and explanation of the need to take medication should be provided to R21, along with writing a progress note. During an interview on 4/7/26 at 9:36 a.m., DON was unaware if staff had been documenting refusals of medications in the progress notes recently but knew it had been done in the past. DON did not realize R21 did not have a care plan regarding cirrhosis of liver.	F0657		05/27/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F0689	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who drafted or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 13 supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed ensure comprehensive assessments for appropriate sling sizes for full body mechanical lift according to manufacturer guidelines to ensure safe transfers to mitigate the risk of injury for 2 of 2 residents (R16, R10) reviewed for safety. Findings include: R16 R16's face sheet dated 4/2/26, identified diagnoses of encounter for closed fracture with routine healing, and muscle weakness. R16's admission MDS dated 2/11/26, identified R16 had severe cognitive impairment. R16 was dependent on staff for dressing, rolling, and transfers. R16 did not move from sitting to lying, lying to sitting, or sitting to standing. R16's Baseline Care Plan dated 2/5/26, identified R16 required staff assistance to transfer but did not identify how the transfer would be accomplished. R16's care plan dated 3/3/26, identified R16 required a mechanical lift with assist of two people for transfers. R16's care plan did not identify sling size to use prior to start of survey. During an observation on 4/2/26 at 9:05 a.m., R16 was in bed. R16's mechanical lift sling tag had the printing dissolved and unable to read the sling size. During an observation on 4/2/26 at 10:50 a.m., licensed practical nurse (LPN)-A and nursing assistant (NA)-A transferred R16 with the unmarked sling and mechanical lift from bed to wheelchair. During an interview on 4/2/26 at 11:10 a.m., NA-A stated NA's decide what sling to use by resident weight. R16 was a medium sling based on weight which had brown straps. The slings used to say what size they were, but they have become worn from washing. The Kardex should include what size sling to use with the lifts. NA-A reviewed R16's and R10's Kardex and verified neither had a sling size identified on the Kardex. NA-A went to the linen closet and identified a sign from the mechanical lift company that stated small slings that had gray straps were for 70-100 pounds, beige straps for	F0689	Continued from page 13 F0689 – Free of Accident Hazards/Supervision/Devices The facility failed to ensure comprehensive assessments for appropriate sling sizes for full body mechanical lift according to manufacturer guidelines to ensure safe transfers to mitigate the risk of injury for 2 of 2 residents (R16 and R10)reviewed for safety. Policy Statement It is the policy of Parkview Care Center to comply with all state and federal regulations, including F0689, to ensure the health, safety, and welfare of all residents. The facility is committed to providing comprehensive assessments and following manufacturer guidelines for equipment use, including mechanical lifts and slings, to mitigate the risk of injury during resident transfers. Corrective Actions for Residents Affected by the Deficient Practice The following corrective actions were taken for residents directly affected: Resident R16: Immediately reassessed for appropriate sling size by a DON and RN-A according to manufacturer guidelines. The care plan and CNA Kardex were updated to reflect the correct sling size after proper assessment was completed. A Comprehensive Assessment form was prepared and implemented for mechanical lift sling size assessment and standing lift harness size assessment. It was used to complete assessments for all residents who require a mechanical lift transfer. Licensed nurses were re-educated on the new sling sizing assessment form, following the manufacturer's guidelines, and on how to assess for the correct sling/harness size. Non-licensed staff were educated on who can assess for sling size (nurses only), following the Kardex for the correct size per resident.	05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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F0689 SS = D	Continued from page 14 medium sling with weight 90-220 pounds, burgundy straps for large with weight 190-320 pounds, and extra-large green straps with weight 280-450 pounds. The signage also included measurements from base of neck to tailbone. Small 21 inches, medium 24 inches, large 26 inches, and extra-large 28 inches. NA-A did not acknowledge the measurement of neck to tailbone in the calculation for sling size when she determined what sling to use. NA-A then reported to LPN-A that R10's and R16's Kardex did not include what size sling to use. During an interview on 4/2/26 at 1:53 p.m., RN-A provided a Comprehensive Assessment for Sling Sizing she had just created. The facility would begin utilizing this immediately. In review of R16's record, there was no indication of a completed comprehensive assessment to determine sling size prior to the start of the survey on 4/2/25. R16's record on 4/2/26 included a completed Comprehensive Assessment for Sling Sizing for Total Lift dated 4/2/26, identified R16 weighed 101.9 pounds and measurement from base of neck to tailbone was 22 inches. R16's sling size was medium. On 4/2/26, R16's care plan was updated to include use of medium mechanical lift sling. R10's face sheet dated 4/2/26, identified diagnoses of spinal stenosis (narrowing of spaces within the spinal canal), lumbago with sciatica on left and right side (pain in lower back and legs due to nerve compression), and age-related physical debility. R10's quarterly Minimum Data Set (MDS) dated 1/28/26, identified R10 had no memory issues. R10 was dependent on staff for dressing, rolling side to side, sitting to lying, sitting to standing, chair/bed transfers. R10's care plan revised 8/18/25, identified R10 required a (full body) mechanical lift with two staff assist for all transfers. R10's care plan did not identify the size of sling to use with the lift In review of R10's record, there was no indication of a completed comprehensive assessment to determine sling size prior to the start of the survey on 4/2/25. R10's record on 4/2/26 included Comprehensive Assessment for Sling Sizing for Total Lift dated 4/2/26, identified R10 weighed 143.3 pounds and measurement from base of neck to tailbone was 22 inches. R10's sling size was medium.	F0689	Continued from page 14 Resident R10: Immediately reassessed for appropriate sling size by a DON and RN-A according to manufacturer guidelines. The care plan and NA Kardex were updated to reflect the correct sling size after proper assessment was completed. A Comprehensive Assessment form was prepared and implemented for mechanical lift sling size and standing lift harness size. Licensed nurses were re-educated on the new assessment form, following the manufacturer's guidelines, and on how to assess for the correct sling size. Non-licensed staff were educated on who can assess for sling size (nurses only), following the Kardex for the correct size per resident. NA-B and NA-C were re-educated on the sizing for mechanical lift slings that can only be determined by licensed nurses. If they are unsure, they need to check with the charge nurse before applying the sling. Sling sizes will now be available in the care plan and kardex. DON was re-educated that only an RN can train nursing staff on the use of mechanical lifts. NAs can not complete any lift training. Actions to Identify Other Potentially Affected Residents A comprehensive review of all residents who require mechanical lift transfers was immediately conducted to identify any residents potentially affected by the same deficient practice. This review included: An audit of all care plans for residents using mechanical lifts to ensure the correct sling/harness size is documented. Completion of the Comprehensive Sling or harness Assessment form for each resident requiring a mechanical lift to confirm appropriate sling/harness size per manufacturer guidelines was completed.	05/27/2026

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F0689 SS = D	Continued from page 15 R10's Kardex dated 4/2/26, identified R10 transferred with the mechanical lift using a medium sling. During an interview on 4/2/26 at 1:25 p.m., NA-B stated sizes of the sling are on the slings. Each sling has a weight limit and the sign in the linen closet would tell them what size sling to use based on weight. During an interview on 4/2/26 at 3:10 p.m., NA-C stated she was unsure how to determine what size of sling to use on residents but "if they are bigger get a large, if smaller get a small". NA-C thought the sling sizes would be included on residents Kardex. During an interview on 4/2/26 at 11:21 a.m., RN-A stated sling sizes should be in the care plan and Kardex. NAs cannot choose size of sling. Sizing of slings should be completed by therapy or nursing department. Sizing would be determined by measuring from neck to tailbone and current weight of resident. RN-A expected the sling sizes to be included in the care plan and Kardex for staff. During an interview on 4/7/26 at 9:36 a.m., DON stated staff are trained on mechanical lift upon hire. The NA's are able to train staff on mechanical lifts. DON measured sling sizes for residents The facility Safe Resident Handling/Transfers undated, identified the facility will ensure that there are appropriate amounts of varying sizes of slings to accommodate residents and that residents will be measure correctly as per the manufacturer's instructions on proper sling size. The EZ Way Smart Lift Operators Instructions undated, identified for safe operation, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients. As patients vary in size, shape, weight, and temperament, these conditions must be taken into consideration when deciding which sling is suitable for each patients needs. The size/weight designations are merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of a patient. A proper fit will involve the judgement of the caregiver. *it is important to evaluate the width of a patient in relation to the width of the sling. **it is important that no portion of the patient overlap the sides of the sling.	F0689	Continued from page 15 Size and coloring were added to their care plans and kardex. Lift slings that were in good repair with faded sizing labels were relabeled according to the color coding listed on the EZ Way manufacturer's guidelines. Measures to Ensure the Deficient Practice Does Not Recur Staff Education and Training: All nursing staff received mechanical lift use training with a return demonstration, which included but was not limited to: Licensed nurses were re-educated on the new assessment form and adherence to following the manufacturer's guidelines, and how to assess for the correct sling/harness size. Non-licensed staff were educated on who can assess for sling/harness size (nurses only), following the Kardex for the correct size per resident. The therapy supervisor will be trained in doing lift competencies so she can complete them with all therapy staff. Policy and Procedure Review: The policy and procedure "Safe Resident Handling/Transfer" regarding mechanical lift use, lift sling/harness assessments, and resident transfer safety was reviewed and revised to align with best practices and regulatory standards. Monitoring to Ensure Effective Implementation of Actions The Director of Nursing (DON) or designee will assess all new admissions and ensure a comprehensive sling assessment has been completed and added to the baseline care plan, and then to their care plan.	05/27/2026

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F0689 SS = D		F0689	Continued from page 16 The Director of Nursing (DON) or designee will audit all of the residents requiring mechanical lift transfers weekly for one month and then 2 residents requiring mechanical lift transfers weekly for 2 months to ensure comprehensive assessment forms for sling size are completed and documented, and that Manufacturer guidelines are followed for all transfers and sling sizing. Audit results will be reviewed during the weekly QAPI committee meetings. The QAPI committee will assess audit outcomes and determine if further monitoring, education, or policy revisions are required. Audit results will be presented at the quarterly QAA meeting. Continuous Improvement: Any identified issues will be addressed immediately, and additional staff training or corrective action will be provided as needed. Person Responsible to Maintain Compliance The Director of Nursing, Administrator, and Assistant Administrator will oversee the implementation and ongoing compliance efforts related to this Plan of Correction. Completion Date May 27, 2026	05/27/2026

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20000	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 4/2/26, 4/3/26, and 4/7/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54369780C (2967413) with a licensing order issued at 0570	20000		05/27/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**

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20000	Continued from page 1 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 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 surveyor's 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 the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		05/27/2026
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven	20570	Corrected.	05/27/2026

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20570	Continued from page 2 days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to revise behavioral care plan after resident-to-resident altercation for 1 of 1 resident (R11) reviewed for abuse. In addition, the facility failed to revise the care plan to reflect ongoing pattern of medication refusals for 1 of 1 resident (R21) who was prescribed a clinically significant medication used to treat a diagnosis of cirrhosis/hepatic failure. Findings include: R11’s face sheet dated 4/2/26, identified diagnoses of Alzheimer’s disease with late onset, anxiety disorder, mild cognitive impairment, and blindness of right eye. R11’s physician order dated 6/12/24, identified to monitor and note behavior in progress note of irritability, verbal aggression, stating he feels down or blue, not visiting with others, walking the halls, and not eating. R11’s physician order dated 6/8/25, identified to check R11’s room daily for weapons such as scissors, knives, forks, etc. after recent episodes of aggression. R11’s quarterly Minimum Data Set (MDS) dated 1/21/26, identified R1 had some difficulty with hearing and speech clarity. R11 was rarely understood and had severe cognitive impairment. R11 had inattention and disorganized thinking. R11 had behavioral problems which included physical behavioral symptoms directed towards others and verbal behavioral symptoms directed towards others. R11 rejected care and wandered 1-3 days. R11 was independent with a wheelchair. R11’s care plan dated identified, R11 exhibited a behavior of inappropriate touching of females dated 5/28/24 with associated interventions that included administer medication as ordered; caregivers provide opportunity for positive interaction and attention; Stop and talk to R11 when passing by; Intervene as necessary to protect the rights and safety of others; Approach/speak in a calm manner. Divert attention; Remove from situation and take to alternate location as needed; Monitor behavior	20570		05/27/2026

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20570	Continued from page 3 episodes and attempt to determine underlying cause; Monitor R11's whereabouts when his room entry motion sensor alarm goes off to see if his is leaving his room to monitor where he is going; Social service designee will discuss behavior with resident and explain/reinforce why it is inappropriate and/or unacceptable to touch other residents, especially females inappropriately one day every week. R11's care plan dated 6/1/25, identified R11 had incidents of verbal aggression with resident 1120. R11 had been asked to move tables in the dining room and refused. R11 and resident 1120 get along much of the time. Interventions included analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Do not wake R11 when sleeping as this can agitate him. Monitor/document/report as needed any signs/symptoms of R11 posing danger to himself and others. Staff to monitor R11's whereabouts and what he is doing when out of his room and around resident 1120. If able, try and get R11 to leave situation. If it is mealtime, tell R11 he can come back in a little while. R11's progress note dated 12/29/25 at 10:26 a.m., identified R11 had been agitated all day. At 8:30 a.m., R11 was outside of his room, in hallway and another resident walked by. R11 swung at the other resident. The other resident ducked. R11 did not make contact with his fist on the other resident. Staff members observed and went to residents. Went to R11's room and he pointed at his bed which appeared wet. Wondered if R11 thought the other resident had wet his bed. The other resident appeared frightened. It was also reported that when nursing staff was assisting R11 to the breakfast table, he hit out at another resident sitting next to him but did not make contact. Later in the morning, the other resident that R11 had previously struck out at, was in the dining room. R11 went up to the resident and was mumbling in anger. The other resident was frightened and put his arms up and walked away from R11 to the other side of the dining room without his walker because R11 was close to the walker. Staff intervened and got the other resident his walker. In review of R11's record it was not evident care plan interventions were evaluated for effectiveness after the incident and R11's care plan did not identify the new aggression toward another resident and staff nor new interventions to manage the behaviors R11 displayed on 12/29/25.	20570		05/27/2026

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20570	Continued from page 4 During an observation on 4/2/26 at 1:19 p.m., R11 was in his room. R11's room was located on the opposite side of facility as R12. During an interview on 4/2/26 at 1:20 p.m., nursing assistant (NA)-D stated R11 was both aggressive and not aggressive depending on time of day and approach. NA-D had never seen R11 aggressive towards residents, only staff. R11 would kick and hit at staff. NA-D tried to maintain a healthy distance away from R11 if R11 was being aggressive. NA-D would allow R11 to calm down before reapproaching for cares if he was aggressive. NA-D was unaware of incident between R11 and R12 in December. During an interview on 4/2/26 at 1:25 p.m., NA-B stated R11 could be aggressive but had never witnessed aggression towards other residents. R11 would show aggression to staff if NA's woke him up before he wanted to get up, when that would happen it would affect R11's whole day. R11 would be upset and chase the NA's around the facility. R11's Kardex identified to intervene as necessary, to protect and approach in calm manor, remove from situation, and take to an alternate location as needed. NA-B stated she would intervene before R11's agitation escalated, engage calmly in conversation and approach later if needed. During an interview on 4/7/26 at 9:36 a.m., director of nursing (DON) stated after the incident on 12/29/25, R11 and R12 were separated from each other and asked to stay away from each other as much as possible. DON did not revise R11's care plan interventions after the altercation to identify aggressive/agitative behaviors toward R12 and staff. Root cause of incident was that R11 did not know or realize what he was doing. R21's face sheet dated 4/3/26, identified diagnoses of chronic hepatic failure without coma, and alcoholic cirrhosis of liver without ascites. R21's care plan dated 9/4/25, identified R12 had diagnoses of constipation and is at risk for constipation when refuses medication for constipation, is receiving laxatives-Lactulose and MiraLAX for management related to diagnoses of cirrhosis of liver. Will refuse other medications for bowels. Interventions included administer medications as ordered. Document if he refuses. Encourage R21 to sit on toilet to evacuate bowels if possible. Follow facility protocol for bowel management. Document if R21 refuses to follow protocol to help evacuate bowels. Provide pericare	20570		05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20570	Continued from page 5 after each incontinent episode. R21's care plan dated 1/26/26, identified R21 can be resistive to cares. Often refuses medications and hygiene. Interventions included to allow R21 to make reasonable decisions about treatment regime to provide sense of control. R21's quarterly MDS dated 3/4/26, identified R21 had no cognitive impairment. R21 rejected cares 1-3 days. R21's physician orders signed 3/19/26, identified an order for Lactulose. Give 45 milliliters (ml) by mouth three times a day related to hepatic failure. R21's medication administration record (MAR) dated 3/2026, identified Lactulose scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m. All administrations reviewed from 3/1/26-3/31/26, with only 19/93 administrations administered. R21's Provider Notification Form dated 3/18/26, identified R21 continued to refuse medications. Medical doctor (MD)-A replied he would address on nursing home rounds. R21's physician visit note dated 3/19/26, did not address the medication refusals as indicated by the physician notification form dated 3/18/26. R21's MAR dated 4/2026, identified Lactulose order which was scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m.; 19 of possible 19 administrations reviewed from 4/1/26 through 4/7/26 at 8:00 a.m., were signed with a "2", which indicated drug refused. Review of R21's progress notes between 4/1/26 through 4/7/26 did not include follow-up and/or address R21's refusals of Lactulose. R21's record reviewed between 3/4/26 through 4/7/6 revealed even though R21 had ongoing refusals of lactulose (74 doses) according to March 2026 MAR, April MAR and R21's Provider Notification Form dated 3/18/26, that identified R21 continued to refuse medications there was no indication the care plan for refusals was reviewed and evaluated for effectiveness and updated to address R21's treatment needs, associated risks (i.e.- encephalopathy), patterns of the refusals and individualized interventions to manage the behavior. During an interview on 4/3/26 at 1:21 p.m., trained medication aide (TMA)-A stated if a resident refused	20570		05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**

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20570	Continued from page 6 a medication, the nurse needed to be notified right away. TMA-A was unable to articulate why R21 took Lactulose and what staff should monitor for when he refused it. During an interview on 4/3/26 at 1:39 p.m., licensed practical nurse (LPN)-A stated R21 took Lactulose for chronic constipation. R21 would refuse a lot and would need coaxing to take medication. If medications were refused for three days the doctor should be notified. LPN-B could not find anything in R21's care plan for the management of hepatic failure/cirrhosis aside from bowel management and was unable to articulate R21's risks associated with the diagnosis of hepatic failure/cirrhosis and unable to identify appropriate associated monitoring systems for sign/symptoms of worsening condition. During an interview on 4/3/26 at 3:03 p.m., registered nurse (RN)-B stated R21 took Lactulose for an alcoholic liver. R21 refused medications often. Education and explanation of the need to take medication should be provided to R21, along with writing a progress note. During an interview on 4/7/26 at 9:36 a.m., DON was unaware if staff had been documenting refusals of medications in the progress notes recently but knew it had been done in the past. DON did not realize R21 did not have a care plan regarding cirrhosis of liver. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident ensuring the care plan is up-to-date and meeting each individual residents needs. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure care plans are correct. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20570		05/27/2026