Electronically Delivered
April 13, 2021

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

RE: CCN: 245436
Cycle Start Date: February 8, 2021

Dear Administrator:

On April 12, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
March 2, 2021

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

RE: CCN: 245436
Cycle Start Date: February 8, 2021

Dear Administrator:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by May 8, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 02/08/2021

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 000	INITIAL COMMENTS On 2/8/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED with deficiency: H#5436013C (MN61057). Deficiency issued at F689. H#5436014C (MN67495). Deficiency issued at F689. The following complaints were found to be UNSUBSTANTIATED: H#5436011C (MN60756) H#5436012C (MN61024) H#5436015C (MN67959) H#5436016C (MN68969) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		3/17/21

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

Electronically Signed | 03/09/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 689	Continued From page 1 §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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate causal factors for falls and failed to ensure interventions were implemented to reduce the risk of falls for 1 of 3 residents (R3) who was reviewed for accidents. In addition, the facility failed to provide adequate supervision for 1 of 2 residents (R4) reviewed for elopement. Findings include: R3's admission record indicated an admission date of 10/8/18, with diagnosis that included; cerebral vascular accident (CVA) with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move one side of the body), aphasia (loss of ability to understand or express speech), dyslexia (learning disorder), weakness and peripheral autonomic neuropathy (damage to nerves resulting in numbness and pain, usually in hands and feet). R3's quarterly Minimum Data Set (MDS) assessment dated 11/11/20, identified R3 as having a baseline interview for mental status (BIMS) score of "12" (meaning moderate cognitive impairment). R3 required extensive assist of two staff for bed mobility, transfers and walking. R3 utilized a wheelchair for mobility. R3 had 2 or more falls either since admission or the	F 689	F-689 Falls: A root cause analysis was completed for each of the resident's falls. The resident was evaluated by the therapy department and adjustments made to the seat of her wheelchair with a non-slip layer added. Therapy is ongoing at this time. Resident education was completed related to self-transfer. Other interventions included a fall mat placed next to her bed, a non-slip liner placed in her wheelchair seat and non-slip footwear. The resident's care plan was updated to include interventions. Staff were educated about the new interventions implemented. If resident has no further falls, facility will state that interventions have been successful and resident has no further falls. The DON reviewed all residents in the facility. All residents have a fall assessment completed. Any resident assessed as at risk for falls has the potential to be affected. The DON and MDS Coordinator reviewed all fall incidents to ensure a root cause analysis was completed. Responses and interventions were documented in the	

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F 689	Continued From page 2 last assessment. R3's current fall assessment dated 2/3/21, identified R3 as having a history of falls. R3 has a weak gait and overestimates and forgets limits. R3 utilizes a wheelchair for mobility and requires staff assistance. The assessment identified R3 as being at high risk for falling R3's care plan, last reviewed 9/23/20, indicated impaired cognitive function and thought process related to dementia. R3 had an activities of daily living (ADL's) deficit related to right sided weakness from a stroke. R3 required assist of 1-2 staff and a walker with transfers and 1-2 staff with bed mobility. The care plan identified R3 as being at risk for falls related to right sided weakness from a stroke. R3 had impaired balance with transitions. Interventions listed for prevention of falls included; assure resident is wearing clean eyeglasses, encourage to use environmental devices such as grab bars, give the resdient verbal reminders to not ambulate or transfer without assistance, R3 had several falls that did not include a root cause analysis to determine potential contributing factors or new intervention to prevent further falls. Falls included the following incidents: -A fall incident report dated 5/21//20, indicated R3 was found lying on the floor next to her bed. The resident stated she slid out of bed on to the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated 8/9/20, indicated R3 was found lying on the floor next to her wheelchair by the bed. R3 stated she slid out of	F 689	notes section of each incident report. The IDT (inter-disciplinary team)completed a root cause analysis for any that were incomplete for current residents. The DON and MDS Coordinator reviewed all care plans. Fall interventions were adequate and no updates were needed. Policy and Procedure related to falls was reviewed. The policy is adequate, and no changes were made. The staff nurses and IDT were educated on how to complete a thorough root cause analysis for all incidents, including falls. Education included "10 Considerations to Think About When a Resident Falls". Education was completed with all staff nurses and IDT to ensure new interventions are implemented after each fall. Education was completed with all staff related to root cause analysis and that everyone is encouraged to provide input for fall prevention. Education also included how staff will be informed when new interventions are implemented. The Safety will meet quarterly and will evaluate falls in addition to other matters of resident safety in our community. Will report recommendations to QAPI. Audits will be completed by the Administrator weekly for three months to ensure 1)root cause analysis is completed for falls, 2)new interventions are implemented after each fall. Results will be reviewed by the QAPI Committee to determine frequency of ongoing audits. F-689 Elopement:	

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F 689	Continued From page 3 her wheelchair on to the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated 9/1/20, indicated R3 was found lying on the floor between the wheelchair and bed. R3 stated she was trying to transfer self in to the wheelchair and slid on to the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated 10/6/20, indicated R3 was found lying on the floor near the bathroom doorway in her room. The resident stated she slid out of her wheelchair on to the floor. No injuries were noted. There were no new interventions implemented. -A fall incident report dated 10/16/20, indicated R3 was found lying on the floor in front of the bed. The resident stated she slid on to the floor. (did not specify if it was from bed or wheelchair) No injuries were noted. A clip alarm was implemented to R3's wheelchair. Although a clip alarm to R3's wheelchair was implemented on 10/16/20, there was no assessment to determine why the resident continued to slide out of her bed/wheelchair. In addition, there were no specific interventions implemented to prevent R3 from further sliding out of the bed/wheelchair. Observation on 2/27/21, at 12:15 p.m. R3 was sitting in her wheelchair in her room watching TV. R3 was not sitting straight up in her wheelchair and observed to be leaning forward slightly R3 noted to have a clip alarm on her wheelchair. There was no non-slip device on the wheelchair.	F 689	The resident was placed on hourly checks. A pager system was purchased. When the wander-guard is triggered, it will send an alert to the pager and staff will be notified immediately. If the resident attempts to leave the building via a door that is not within hearing distance of staff, the staff will be notified through the pager and can take action right away. The DON reviewed all residents in the facility. All residents who are an elopement risk have the potential to be affected. All residents assessed as being at risk for elopement have a wander-guard bracelet. The new pager system will ensure are alerted immediately if any resident triggers the wander-guard alarm. Policies and procedures related to elopement were reviewed. The elopement policy was updated to include use of pager as another means to alert staff when a door alarm has been triggered. The Emergency policy was updated to include required use of pager as part of the wander-guard system. Preventive maintenance policy was updated to ensure there are adequate supplies of pager and to ensure they are in good working order. Nursing staff were educated on how to use the pager and on the importance of having it on their person so they are immediately aware if a door alarm was triggered. The Safety Committee will meet quarterly and will evaluate elopement attempts in addition	

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F 689	Continued From page 4 R3 was unable to be interviewed due to impaired cognition. Interview on 2/8/21, at 12:15 p.m. nursing assistant (NA)-E indicated she was aware of R3's fall risk and current interventions. NA-E indicated R3 requires assistance of staff with all transfers and seldom uses the call light for assistance. NA-E indicated R3 will attempt to transfer self frequently and confirmed most of R3's falls had been from sliding on to the floor from the bed or wheelchair. NA-E confirmed there were no non-slip interventions to R3's wheelchair or bed that she knew of. Interview on 2/8/21, at 12:30 p.m. the director of nursing (DON) confirmed R3's wheelchair clip alarm was not included in the plan of care nor were new interventions implemented for R3's falls. The DON indicated the facility interdisciplinary team did not thoroughly review falls to determine the causal factors of the falls, to implement new interventions. The DON further confirmed most all of R3's falls occurred from either sliding out of bed or wheelchair, but no interventions had been reviewed specific to the cause. Review of the facility policy Falls and Fall Risk, Managing reviewed on 1/21, directed the staff to identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on	F 689	to other matters of resident safety in our community. Will report recommendations to QAPI. Audits will be completed weekly on each shift for one month to see if staff have the pager on their person and to see if they are aware of how to use it. Then audits will be done each shift every two weeks for one month and then each shift monthly for one month. Results will be reviewed by the QAPI Committee to determine frequency of ongoing audits. The QAPI committee will review policies and procedures to ensure revisions are made to review for any on-going revisions. Policies will be reviewed annually.	

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assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable
R4's facesheet printed on 2/8/21, indicated diagnosis of dementia without behaviors.

R4's quarterly Minimum Data Set (MDS) assessment dated 11/11/20, indicated R4 had severe cognitive impairment; clear speech, was able to make self understood and could understand others. R4 had adequate vision, minimal difficulty hearing, was dependent upon staff for bed mobility, transfers, walking, locomotion off the unit, dressing and toileting.

R4's most recent care plan printed by the director of nursing (DON) on 2/8/21, indicated R4 was an elopement risk and wanderer related to impaired safety awareness. Interventions included: disguise exits, stop signs on doors on east end of building, and staff were to check on R4 every hour to know his whereabouts. In addition, R4 had a wanderguard bracelet on his wheelchair to alert staff of attempts to leave the facility.

R4's quarterly wandering risk assessment score dated 11/11/20, was 12, indicating R4 was a high risk to wander.

A progress note dated 11/19/20, at 4:45 p.m. indicated the facility received a phone call from a citizen who stated a resident was outside on the east end of the building wheeling down the street. Staff went outside to intervene and found R4 in the street close to the curb, in his wheelchair without a coat. R4 was resistant to being brought back into the building, yelling "you can't do a damn thing around here." Estimated length of

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F 689	Continued From page 6	F 689		

time outside was 10 minutes. Following the elopement, staff implemented hourly checks.

During an interview on 2/8/21, at 12:00 p.m., registered nurse (RN)-A stated R4 used to reside in room 31, and "oh, he liked to wander." RN-A stated R4 had a wanderguard on his wheelchair which would activate a door alarm if he went through an exit door. RN-A stated she could hear the alarm most of the time, but not if she was in a resident room with the door closed.

During an interview on 2/8/21, at 12:10 p.m., licensed practical nurse (LPN)-A stated R4 liked to wander in the hallway and sometimes left the facility through an exit door. LPN-A stated R4 had a wanderguard bracelet attached to his wheelchair and this activated an alarm when he went through an exit door. LPN-A added when the alarm went off, the door being exited displayed on the nurse call light marquee too and this was how staff knew which door a resident was exiting. LPN-A stated she was not always able to hear the alarm, especially when in a residents room or further down the hallway. LPN-A stated the alarm got their attention, then staff were to look at the marquee to see which door was being exited and respond to that door.

During an interview on 2/8/21, at 12:16 p.m., nursing assistant (NA)-A stated R4 had a wanderguard which would activate an alarm if he exited the building. NA-A stated she was not always able to hear the door alarm when it sounded if she was in a residents room or if resident TV's were loud.

During an interview on 2/8/21, at 12:39 p.m., the DON identified the east exit door that R4 went

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through on 11/19/20; it was a double egress exit door with clear glass. The DON admitted staff not being able to hear the door alarm when a resident exited the building had been an issue for awhile, adding that the alarm on the east end of the building was hard to hear unless standing right next to it. The DON stated the alarm was supposed to alert staff to a resident exiting the building, then staff were to look at the nurse call light marquee to identity which door. The DON stated there had been discussions about updating the doors and alarm system but it had not been done.

During an interview on 2/8/21, at 12:42 p.m., maintenance supervisor (MS)-A sounded the east exit door alarm. The alarm was loud standing next to the door with the inside egress door open, but significantly muffled when closed. MS-A stated the alarm only sounded at the door; there were no speakers elsewhere in the building. MS-A stated the system was obsolete as parts were no longer available. MS-A stated the facility had been looking into possibly replacing the system. MS-A admitted that staff further down the hallway would not likely hear this alarm when it sounded.

During an interview on 2/8/21, at 1:33 p.m. the administrator stated the DON informed him about elopement incidents and they were discussed at the quality committee. The administrator didn't know if frontline staff were involved in discussions about not hearing the door alarms. Administrator stated the nurse call light system had been upgraded, but the project did not include the doors and alarms, adding they had talked about upgrading doors next. The administrator admitted staff would not notice the name of an exit door

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F 689	Continued From page 8	F 689		

scroll on the nurse call light marquee unless they happened to be looking at it.

During a telephone interview on 2/8/21, at 1:41 p.m., (RN)-B who had been working when R4 eloped on 11/19/20, stated she recalled the incident and that R4 exited the east entrance. RN-B stated they got a phone call from a neighbor that R4 was found on the side of street by the neighbors house. RN-B stated no one heard the alarm, as they were all in rooms getting residents ready for supper, adding the alarm was so far away.

During an interview on 2/8/21, at 1:50 p.m., social services (SS)-A who completed the report to the State agency stated she received a call at home after R4's elopement on 11/19/20, adding staff informed her they did not hear the alarm because they were in the rooms with residents.

MS-A provided distances from various locations in the facility to the alarm on the east exit door:
--From room 32, which was a resident room closest to the east exit = 122 feet
--From east exit door to east nurses station = 164 feet
--From east exit door to west nurses station = 319 feet
--From east exit door to west exit door = 449 feet

During an audible test done on 2/8/21, at 3:00 p.m., MS-A sounded the alarm and two surveyors walked to various points away from the alarm. At room 32, could barely hear the alarm and could only hear it because was listening for it. Could not hear the alarm at the east nurses station, west nurses station or west exit. Staff interviewed during this time:

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	245436	A. BUILDING _____ B. WING _____	C 02/08/2021

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 689	Continued From page 9 ---3:04 p.m.- NA-A did not hear alarm from the east hallway by room 32 ---3:07 p.m. (RN)-C did not hear alarm at east nurses station ---3:08 p.m. (LPN)-B did not hear alarm at west nurses station During an interview on 2/8/21, at 4:53 p.m., the administrator stated they have known since April 2020, that staff cannot hear exit door alarms when far down the hallway or when in resident rooms. The administrator added that addressing the issue was still in the discussion phase and the facility had not identified a remedy for staff not being able to hear a door alarm when a resident was exiting the building. The administrator admitted the trigger for staff to be alerted to a resident exiting the building was hearing the door alarm; that an exit door number scrolling across the nurse call light marquee would not alone be sufficient. Facility policy titled Emergency Procedure - Missing Resident, with revised date of March 2018, indicated: 1. Residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety. 2. Staff will implement policy for missing resident immediately upon discovery that a resident cannot be located. Facility procedure titled Environmental Restraints (Wanderguard), undated, indicated wanderguard devices were placed on an assistive device or to the resident directly and would be checked daily for proper function. Other equipment was to be maintained and serviced by maintenance and/or wanderguard service technician.	F 689		

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F 689	Continued From page 10 Facility policy titled Wandering and Elopement with revised date of March 2019, indicated steps to take after a resident is identified as missing. It did not address how to prevent residents from eloping.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 2, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: UG0D11

Dear Administrator:

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

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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:

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

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
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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 2/8/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that 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 complaints were found to be SUBSTANTIATED: H#5436013C (MN61057), H#5436014C(MN67495) with a licensing order issued at MN Rule 4658.0520 Subp. 1 The following complaints were found to be UNSUBSTANTIATED: H#5436011C (MN60756), H#5436012C (MN61024), H#5436015C (MN67959), H#5436016C (MN68969). 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 surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate causal factors for falls and failed to ensure interventions were implemented to reduce the risk of falls for 1 of 3 residents (R3) who was reviewed for accidents. In addition, the facility failed to provide adequate supervision for 1 of 2 residents (R4) reviewed for elopement.	2 830	Corrected	3/17/21

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2 830	Continued From page 3 Findings include: R3's admission record indicated an admission date of 10/8/18, with diagnosis that included; cerebral vascular accident (CVA) with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move one side of the body), aphasia (loss of ability to understand or express speech), dyslexia (learning disorder), weakness and peripheral autonomic neuropathy (damage to nerves resulting in numbness and pain, usually in hands and feet). R3's quarterly Minimum Data Set (MDS) assessment dated 11/11/20, identified R3 as having a baseline interview for mental status (BIMS) score of "12" (meaning moderate cognitive impairment). R3 required extensive assist of two staff for bed mobility, transfers and walking. R3 utilized a wheelchair for mobility. R3 had 2 or more falls either since admission or the last assessment. R3's current fall assessment dated 2/3/21, identified R3 as having a history of falls. R3 has a weak gait and overestimates and forgets limits. R3 utilizes a wheelchair for mobility and requires staff assistance. The assessment identified R3 as being at high risk for falling R3's care plan, last reviewed 9/23/20, indicated impaired cognitive function and thought process related to dementia. R3 had an activities of daily living (ADL's) deficit related to right sided weakness from a stroke. R3 required assist of 1-2 staff and a walker with transfers and 1-2 staff with bed mobility. The care plan identified R3 as being at risk for falls related to right sided weakness from a stroke. R3 had impaired	2 830		

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2 830	Continued From page 4	2 830		

balance with transitions. Interventions listed for prevention of falls included; assure resident is wearing clean eyeglasses, encourage to use environmental devices such as grab bars, give the resdient verbal reminders to not ambulate or transfer without assistance,

R3 had several falls that did not include a root cause analysis to determine potential contributing factors or new intervention to prevent further falls. Falls included the following incidents:

-A fall incident report dated 5/21//20, indicated R3 was found lying on the floor next to her bed. The resident stated she slid out of bed on to the floor. No injuries were noted. There were no new interventions implemented.

-A fall incident report dated 8/9/20, indicated R3 was found lying on the floor next to her wheelchair by the bed. R3 stated she slid out of her wheelchair on to the floor. No injuries were noted. There were no new interventions implemented.

-A fall incident report dated 9/1/20, indicated R3 was found lying on the floor between the wheelchair and bed. R3 stated she was trying to transfer self in to the wheelchair and slid on to the floor. No injuries were noted. There were no new interventions implemented.

-A fall incident report dated 10/6/20, indicated R3 was found lying on the floor near the bathroom doorway in her room. The resident stated she slid out of her wheelchair on to the floor. No injuries were noted. There were no new interventions implemented.

-A fall incident report dated 10/16/20, indicated

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2 830	Continued From page 5 R3 was found lying on the floor in front of the bed. The resident stated she slid on to the floor. (did not specify if it was from bed or wheelchair) No injuries were noted. A clip alarm was implemented to R3's wheelchair. Although a clip alarm to R3's wheelchair was implemented on 10/16/20, there was no assessment to determine why the resident continued to slide out of her bed/wheelchair. In addition, there were no specific interventions implemented to prevent R3 from further sliding out of the bed/wheelchair. Observation on 2/27/21, at 12:15 p.m. R3 was sitting in her wheelchair in her room watching TV. R3 was not sitting straight up in her wheelchair and observed to be leaning forward slightly R3 noted to have a clip alarm on her wheelchair. There was no non-slip device on the wheelchair. R3 was unable to be interviewed due to impaired cognition. Interview on 2/8/21, at 12:15 p.m. nursing assistant (NA)-E indicated she was aware of R3's fall risk and current interventions. NA-E indicated R3 requires assistance of staff with all transfers and seldom uses the call light for assistance. NA-E indicated R3 will attempt to transfer self frequently and confirmed most of R3's falls had been from sliding on to the floor from the bed or wheelchair. NA-E confirmed there were no non-slip interventions to R3's wheelchair or bed that she knew of. Interview on 2/8/21, at 12:30 p.m. the director of nursing (DON) confirmed R3's wheelchair clip alarm was not included in the plan of care nor were new interventions implemented for R3's falls. The DON indicated the facility	2 830		

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2 830	Continued From page 6	2 830		

interdisciplinary team did not thoroughly review falls to determine the causal factors of the falls, to implement new interventions. The DON further confirmed most all of R3's falls occurred from either sliding out of bed or wheelchair, but no interventions had been reviewed specific to the cause.

Review of the facility policy Falls and Fall Risk, Managing reviewed on 1/21, directed the staff to identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.

R4's facesheet printed on 2/8/21, indicated diagnosis of dementia without behaviors.

R4's quarterly Minimum Data Set (MDS) assessment dated 11/11/20, indicated R4 had severe cognitive impairment; clear speech, was able to make self understood and could understand others. R4 had adequate vision, minimal difficulty hearing, was dependent upon staff for bed mobility, transfers, walking, locomotion off the unit, dressing and toileting.

R4's most recent care plan printed by the director of nursing (DON) on 2/8/21, indicated R4 was an elopement risk and wanderer related to impaired safety awareness. Interventions included:

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2 830	Continued From page 7	2 830		

disguise exits, stop signs on doors on east end of building, and staff were to check on R4 every hour to know his whereabouts. In addition, R4 had a wanderguard bracelet on his wheelchair to alert staff of attempts to leave the facility.

R4's quarterly wandering risk assessment score dated 11/11/20, was 12, indicating R4 was a high risk to wander.

A progress note dated 11/19/20, at 4:45 p.m. indicated the facility received a phone call from a citizen who stated a resident was outside on the east end of the building wheeling down the street. Staff went outside to intervene and found R4 in the street close to the curb, in his wheelchair without a coat. R4 was resistant to being brought back into the building, yelling "you can't do a damn thing around here." Estimated length of time outside was 10 minutes. Following the elopement, staff implemented hourly checks.

During an interview on 2/8/21, at 12:00 p.m., registered nurse (RN)-A stated R4 used to reside in room 31, and "oh, he liked to wander." RN-A stated R4 had a wanderguard on his wheelchair which would activate a door alarm if he went through an exit door. RN-A stated she could hear the alarm most of the time, but not if she was in a resident room with the door closed.

During an interview on 2/8/21, at 12:10 p.m., licensed practical nurse (LPN)-A stated R4 liked to wander in the hallway and sometimes left the facility through an exit door. LPN-A stated R4 had a wanderguard bracelet attached to his wheelchair and this activated an alarm when he went through an exit door. LPN-A added when the alarm went off, the door being exited displayed on the nurse call light marquee too and this was how

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2 830	Continued From page 8	2 830		

staff knew which door a resident was exiting. LPN-A stated she was not always able to hear the alarm, especially when in a residents room or further down the hallway. LPN-A stated the alarm got their attention, then staff were to look at the marquee to see which door was being exited and respond to that door.

During an interview on 2/8/21, at 12:16 p.m., nursing assistant (NA)-A stated R4 had a wanderguard which would activate an alarm if he exited the building. NA-A stated she was not always able to hear the door alarm when it sounded if she was in a residents room or if resident TV's were loud.

During an interview on 2/8/21, at 12:39 p.m., the DON identified the east exit door that R4 went through on 11/19/20; it was a double egress exit door with clear glass. The DON admitted staff not being able to hear the door alarm when a resident exited the building had been an issue for awhile, adding that the alarm on the east end of the building was hard to hear unless standing right next to it. The DON stated the alarm was supposed to alert staff to a resident exiting the building, then staff were to look at the nurse call light marquee to identity which door. The DON stated there had been discussions about updating the doors and alarm system but it had not been done.

During an interview on 2/8/21, at 12:42 p.m., maintenance supervisor (MS)-A sounded the east exit door alarm. The alarm was loud standing next to the door with the inside egress door open, but significantly muffled when closed. MS-A stated the alarm only sounded at the door; there were no speakers elsewhere in the building. MS-A stated the system was obsolete as parts

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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) COMPLETE DATE
2 830	Continued From page 9	2 830		

were no longer available. MS-A stated the facility had been looking into possibly replacing the system. MS-A admitted that staff further down the hallway would not likely hear this alarm when it sounded.

During an interview on 2/8/21, at 1:33 p.m. the administrator stated the DON informed him about elopement incidents and they were discussed at the quality committee. The administrator didn't know if frontline staff were involved in discussions about not hearing the door alarms. Administrator stated the nurse call light system had been upgraded, but the project did not include the doors and alarms, adding they had talked about upgrading doors next. The administrator admitted staff would not notice the name of an exit door scroll on the nurse call light marquee unless they happened to be looking at it.

During a telephone interview on 2/8/21, at 1:41 p.m., (RN)-B who had been working when R4 eloped on 11/19/20, stated she recalled the incident and that R4 exited the east entrance. RN-B stated they got a phone call from a neighbor that R4 was found on the side of street by the neighbors house. RN-B stated no one heard the alarm, as they were all in rooms getting residents ready for supper, adding the alarm was so far away.

During an interview on 2/8/21, at 1:50 p.m., social services (SS)-A who completed the report to the State agency stated she received a call at home after R4's elopement on 11/19/20, adding staff informed her they did not hear the alarm because they were in the rooms with residents.

MS-A provided distances from various locations in the facility to the alarm on the east exit door:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00784	A. BUILDING: _____ B. WING _____	C 02/08/2021

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2 830	Continued From page 10 --From room 32, which was a resident room closest to the east exit = 122 feet --From east exit door to east nurses station = 164 feet --From east exit door to west nurses station = 319 feet --From east exit door to west exit door = 449 feet During an audible test done on 2/8/21, at 3:00 p.m., MS-A sounded the alarm and two surveyors walked to various points away from the alarm. At room 32, could barely hear the alarm and could only hear it because was listening for it. Could not hear the alarm at the east nurses station, west nurses station or west exit. Staff interviewed during this time: ---3:04 p.m.- NA-A did not hear alarm from the east hallway by room 32 ---3:07 p.m. (RN)-C did not hear alarm at east nurses station ---3:08 p.m. (LPN)-B did not hear alarm at west nurses station During an interview on 2/8/21, at 4:53 p.m., the administrator stated they have known since April 2020, that staff cannot hear exit door alarms when far down the hallway or when in resident rooms. The administrator added that addressing the issue was still in the discussion phase and the facility had not identified a remedy for staff not being able to hear a door alarm when a resident was exiting the building. The administrator admitted the trigger for staff to be alerted to a resident exiting the building was hearing the door alarm; that an exit door number scrolling across the nurse call light marquee would not alone be sufficient. Facility policy titled Emergency Procedure - Missing Resident, with revised date of March	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 11 2018, indicated: 1. Residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety. 2. Staff will implement policy for missing resident immediately upon discovery that a resident cannot be located. Facility procedure titled Environmental Restraints (Wanderguard), undated, indicated wanderguard devices were placed on an assistive device or to the resident directly and would be checked daily for proper function. Other equipment was to be maintained and serviced by maintenance and/or wanderguard service technician. Facility policy titled Wandering and Elopement with revised date of March 2019, indicated steps to take after a resident is identified as missing. It did not address how to prevent residents from eloping. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. The DON or designee could educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		