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	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Care Center	55 Tenth Street Southeast Wells, MN 56097

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to revise the care plan for 2 of 3 residents (R1, R2) who were reviewed for non-pressure skin concerns and pressure ulcers. Findings includeR1's face sheet dated 1/29/26, identified diagnoses of malignant neoplasm (cancer) of the anal canal. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact, had no behaviors of rejection of care, was independent with bed mobility, needed set up or clean up assistance for transfers, had a recent surgery that required active skilled nursing facility care that involved the gastrointestinal tract, had a surgical wound that did not have any surgical wound care. R1's activity of daily living (ADL) focus care plan dated 1/11/26, identified R1 had a self-care performance deficit related to gastrointestinal surgery. Goal to improve current level of functioning in ADLs. Interventions for transfers dated 1/11/26 as follows: R2 able to transfer with one staff and front wheeled walker, partial assist bed to chair, chair to bed transfers and sitting to standing. R1's Rehab (Therapy) Communication form dated 1/13/26, identified R1 to transfer independent in room with four wheeled walker. During an interview on 1/30/26 at 10:47 a.m., nursing assistant (NA)-C stated she was responsible for caring for R1 today (1/30/26) and believed R1 could be independent in his room but had not verified R1's care plan/Kardex at the beginning of her shift. NA-C verified R1's care plan that he was supposed to be assist of one for transfers. NA-C then found a clipboard with the Rehab communication form that identified R1 changed to be independent on 1/13/26. During an interview on 1/30/26 at 3:19 p.m., director of nursing (DON) stated R1's care plan with transfers stated R1 needed one assist, however, R1's care plan had not been revised in a timely manner to reflect the 1/13/26 physical therapy recommendation to be independent in room with a walker. DON further stated, I just have not had time to update R1's care plan with the new recommendations. R2's face sheet dated 2/4/26, identified diagnoses of chronic kidney failure, heart failure, atrial fibrillation, and pressure ulcer of right heel.R2's admission Minimum Data Set (MDS) dated [DATE], identified R2 had no rejection of care, dependent for needs to roll left and right, dependent with transfers from surfaces, at risk for pressure ulcers/injuries, did not have any unhealed pressure ulcers/injuries and had a surgical wound. R2's activity of daily living (ADL) care plan dated 1/6/26, identified R2 had a self-care deficit related to hip fracture as evidenced by documentation of care needs by direct care staff. Goal to improve current level of function in transfers. Interventions for transfers as follows: -toilet transfer: substantial one staff assist with sit to stand mechanical lift (dated 1/20/26) R2's Rehab Communication Form dated 1/26/26, identified that R2 to discontinue the use of the sit-to -stand mechanical lift and transfer with assist of one with gait belt and wheeled walker. During an observation on 2/3/26 at 10:06 a.m., NA-E was placing R2 on the commode. NA-E then grabbed the walker and applied a gait belt to R2. Surveyor intervened and questioned NA-E about R2's transfer status. NA-E stated R2 was assist of one with transfers with gait (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	belt and walker. NA-E verified that R2's care plan identified R2 needed the sit to stand mechanical lift for transfers to the toilet. NA-E stated she verifies how to transfer a resident with the Rehab communication form verses looking at the care plan/Kardex. NA-E then produced a piece of paper that was identified as Rehab Communication that R2 had been changed to assist of one with gait belt and wheeled walker on 1/26/26. During an interview on 2/3/26 at 10:12 a.m., director of nursing stated R2's transfer status had been changed on 1/26/26 from assist of one with the sit to stand mechanical lift to the use of one with gait belt and walker. DON stated R2's care plan still identified her transfer was with the use of the sit to stand mechanical lift, because she had not had time to update the care plan and this should have been done as soon as the therapy recommendation was received. During an interview on 2/4/26 at 1:17p.m., therapy director (TD) stated that when a resident has a change in transfer status, they provide the nursing department with multiple copies of the Rehab Communication form. TD stated her expectation would be for the residents' care plan to be revised as soon as possible after the recommendation was made and that staff are communicated the change. Review of the facility's Care Plan Revisions Upon Status Change Policy dated 12/25, identified it is the policy of the facility to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: -The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. -Procedure for reviewing and revising the care plan when a resident experiences a status change: Upon identification of a change in status, the nurse will notify the nurse manager, the physician, and the resident representative, if applicable.-The interdisciplinary team (IDT) will discuss the resident conditions and collaborate on intervention options. -The team meeting discussion will be documented in the nursing progress notes. -The care plan will be updated with new or modified interventions. -Staff involved in the care of the residents will report resident response to new or modified interventions. -Care plans will be modified as needed by the DON/nurse manager or other designated staff member. -The nurse manager or other designated staff member will communicate care plan interventions to all staff involved in resident's care.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to comprehensively assess, monitor, timely develop and revise a care plan, and follow physician-ordered treatments for a surgical wound for 1 of 3 residents (R1) reviewed for non-pressure related skin injuries. The facility's failures resulted in actual harm, as evidenced by documented deterioration of R1's surgical wound from partial to complete dehiscence, with measurable increases in wound depth and tunneling, increased pain, and the need for ongoing treatments. Findings include: R1's face sheet dated 1/29/26, identified diagnoses of malignant neoplasm (cancer) of the anal canal. R1's hospital Discharge summary dated [DATE], identified R1 had been hospitalized from [DATE] through 1/2/26 for a planned robotic-assisted abdominoperineal resection (a major surgery removing that anus, rectum, and part of the sigmoid colon) with a permanent colostomy. R1's hospital After Visit Summary dated 1/2/26, included the following post procedure after care orders for the abdominal perineal resection: -No donut pillows - Avoid sitting on hard surfaces for prolonged periods of time. -Be careful when transferring from sitting to standing to avoid shearing. -It is recommended you change positions frequently in order to reduce friction or pressure. -You may sit normally on a regular pillow for ten minutes at a time in an hour period for the next 2-3 weeks. In review of R1's record between 1/2/26 through 1/13/26 there was no indication the aforementioned Hospital's aftercare orders/interventions had been transcribed into R1's facility physician orders. R1's admission Skin assessment dated [DATE], identified a drawing of the perineal area with 7 lines (indicating an incisional line) and a comment of closed due to anal cancer. No additional information was included. During an interview on 1/28/26 at 8:46 a.m., registered nurse (RN)-B stated she had observed R1's coccyx incision on admission and it was closed with sutures and did not observe any dehiscence at that time. R1‘s baseline care plan dated 1/3/26, did not identify any skin integrity issues and/or the incision to R1's rectal area. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact, had no behaviors of rejection of care, was independent with bed mobility, needed set up or clean up assistance for transfers, had a recent surgery that required active skilled nursing facility care that involved the gastrointestinal tract, had a surgical wound that did not have any surgical wound care. R1' s corresponding Care Area Assessment (CAA) signed 1/13/26, did not identify a trigger for any skin issues. Review of R1's record between 1/2/26 through 1/13/26, indicated even though R1's hospital discharge documents and MDS identified R1 had a recent surgery that required active skilled nursing there was no indication of a corresponding baseline and/or comprehensive care plan developed that addressed and/or specified the necessary nursing care/services/or management pertaining to R1's gastrointestinal tract and/or address R1's surgical wound until 1/14/26 (12 days after admission). Furthermore, between R1's admission date of 1/2/26 and 1/14/26, R1's record did not include comprehensive skin assessments nor monitoring of R1's rectal surgical incision. R1's progress note dated 1/14/26, identified there was concern for purulent drainage from the surgical site, called surgeon, and made an appointment to be seen on 1/15/26. Surgeon stated it was ok to wait until appointment, however, if a temperature, pain, nausea or vomiting develop then send to emergency department. R1's skin integrity care plan initiated on 1/14/26, identified actual impairment of skin integrity of the rectal area which has an open wound which dehisced. Goal to develop clean and intact skin. Interventions as followed: -avoid sitting on hard surfaces for prolonged period of time and change positions frequently to reduce friction or pressure, you may sit normally on a regular pillow for 10 minutes at a time in an hour period for the next 2-3 weeks from admission of 1/2/26. R1's physician orders updated on 1/14/26, identified the following orders: -Do not to be (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	sit up for more than 10 minutes at a time in an hour and should be sitting on a pillow, should be changing positions frequently in order to reduce friction or pressure every shift. R1's Skin Issue assessment dated [DATE] at 9:17 a.m., identified a new skin issue of a surgical wound that was present on admission. Incision approximated with partial dehiscence (the splitting or bursting open of a wound). No healing ridge. Measured 21.71 centimeters (cm) x 2.71 cm, with no undermining or tunneling. Had 40% of epithelial (a process where epithelial cells migrate upwards to repair a wound); 50% granulation (a healing wound filled with new, healthy connective tissue); 10% slough (a moist yellow, or white necrotic tissue); had moderate exudate (drainage) that was serous (clear watery fluid). Exudate had strong odor after cleansing; surrounding tissue was intact; periwound (the skin around the wound edge) was warm; dressing intact; dressing saturated; debridement was mechanical in nature; dressing was non-adherent synthetic. Although R1's skin assessment dated [DATE] identified the usage of a dressing, R1's physician orders did not include wound treatment orders and R1's record did not identify type of wound treatment and how long the treatment had been applied. R1's progress note dated 1/15/26 at 11:53 a.m., identified R1 left for appointment at 9:50 a.m. R1's facility ‘s appointment communication form dated 1/15/26, identified the facility informed general surgery R1 had not been offloaded as ordered and had been sitting up for more than 10 minutes an hour and not on a pillow or wheelchair cushion. In review of R1's record between 1/2/26 through 1/13/26 there was no documentation R1 had been offered and/or attempted to offload until the order dated 1/14/26 that directed staff of R2's position changes that was recorded as completed on the January 2026 treatment administration record. Further there was no documentation R1 had refused position changes. R1's surgeon physician orders dated 1/15/26 at 11:00 a.m., directed staff to pack rectal wound 1-2 times per day as needed pre drainage with 1/4 iodoform (a cotton gauze impregnated with an antiseptic agent) packing or plain gauze. R1's General Surgery progress note dated 1/15/26 at 12:32 p.m., included R1 was seen for a follow up after a recent robotic abdominoperineal resection (a major surgery that removes the rectum, anus, and part of the sigmoid colon). R1's nursing facility was concerned about purulent foul-smelling drainage from the perineal incision. Perineal examination performed and showed a partially dehisced perineal wound with a 3.0 cm opening at the cephalad (upper part of the body) aspect of the incision and loose sutures at that area. There was no purulence. The top 3 nylon sutures were removed, and the wound was probed showing a sizable cavity within to at least 4.0 cm in depth. The remaining sutures were kept in place as they appeared to be holding the wound together. The wound was packed and instructed to have packing changed at least once daily and as needed. Discussed offloading the wound and avoid sitting for prolonged periods of time. R1's physician orders dated 1/16/26, directed dressing change/wound packing to rectal/anal wound dehiscence-packing changes at least once daily and as needed for drainage with 1/4 inch iodoform packing strip or plain gauze once per day. R1's Skin Issue assessment dated [DATE], identified wound on coccyx had a surgical wound. Wound is listed as stable: wound previously deteriorating; wound characteristics plateaued. Wound was present on admission; however, exact date was identified at 1/15/26 (13 days after admission). Incision not approximated and had partial or complete dehiscence. Wound measurements documented as 1.2 cm x .72 cm x 3.0 cm with no undermining or tunneling with no exudate odor. Surrounding tissue is fragile and had heavy drainage. Dressing intact but saturated with heavy saturation. R1's facility's provider notification form dated 1/20/26, informed that R1's perineal wound was worsening. Call placed to surgeon on 1/20/26, however, had not received a call back yet. Requested order to change order from packing of 1/4 inch iodoform packing strips or gauze to cleanse wound with gauze and saline to pack with 1/2 inch moistened roll gauze and cover with ABD (abdominal pad- a thick highly absorbent dressing). The (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	wound is too large for 1/4 inch strip. R1's physician orders communication dated 1/22/26, included a response from the 1/20/26 order request to implement wound care as it is written in the nursing note, but we do need to stress to make sure they [general surgery] are ok with continuing that wound care and that they do not have something different. R1's general surgery wound nurse note dated 1/23/26, identified R1 was seen for wound care in clinic and agree to continue to changing packing at least twice daily and to change outer dressing when saturated. R1's general surgery orders dated 1/23/26, directed staff to continue to change outer dressing when saturated. Increase packing on side (use more gauze, pack down towards incision and straight back). Change packing at least twice daily. Ultrasound done and no concerns. Use orange bottle of hydrophilic wound dressing around wound for redness. Continue regular diet, encourage fluids, and high protein. R1's physician orders identified an order on 1/24/26 to pack rectal wound with 1/2 inch roll gauze. Pack more gauze down towards incision and straight back twice daily and use hydrophilic (a dressing designed to maintain moisture) wound dressing around wound for redness. Cover with ABD. Change outer dressing when saturated. R1's progress note dated 1/24/26 at 11:04 a.m., identified old dressing removed from rectal area and large amount of serous drainage without odor. Area cleansed with Vahse (a hypochlorous acid solution designed for cleansing, irrigating, moistening, debriding, and removing foreign material), hydrophilic applied around the wound, and new packing inserted. R1's wound care physician orders did not include an order to use Vashe wound cleanser. R1's progress note dated 1/25/26 at 1:46 p.m., identified wound dressing and packing changed. R1 asked not to have too much packed in there because he could not sleep on either side. R1's record did not identify education was provided to R1 about following physicians' orders, did not include description pertaining to the amount of gauze and amount that was used to replace, no indication of any further assessment and/or evaluation of the discomfort the prescribed treatment caused, and not evident physician and surgical service were notified. R1's progress note dated 1/25/26 at 9:31 p.m., identified R1's coccyx dressing had great deal of odorous drainage from old dressing. R1's pants, underwear, and sheets smelled like drainage. R1's record did not include a comprehensive assessment of the wound nor notification to the physician of the odorous drainage and the increase in drainage. R1's progress note dated 1/26/26 at 10:05 a.m., identified during R1's dressing change there was a good amount of yellow/green strong odorous drainage with scant amount of blood on the packing gauze that was removed. Wound cleansed with Vashe (not in accordance with physician orders) and then packed both areas of the wound. R1's record did not include a comprehensive assessment of the wound. R1's progress note dated 1/26/26, identified a fax was sent to the primary care physician related to drainage from rectal slit area. R1's progress note dated 1/27/26, indicated a return fax received from primary care physician that incisional concerns need to be addressed with surgical team. R1's record reviewed 1/25/26 through 1/28/26 did not identify the surgery team had been notified of the change in the wound characteristics. R1's Skin Issue assessment dated [DATE], indicated R1's wound had deteriorated since the 1/20/26 when the measurements were documented as 1.2 cm x .72 cm x 3.0 cm in depth. The assessment on 1/27/26 identified the wound measurements were 4.3 cm x 0.88 cm x 7.0 cm depth. Had undermining at 12 o'clock of the wound. With one tunnel that measured 6.0 cm at 6 o'clock. With 10% epithelial tissue, 90% granulation and had heavy serous exudate with a strong odor after cleansing. R1's record did not include an analysis of the deterioration nor evident the care plan was revised to prevent/mitigate the risk of further deterioration. R1's progress note dated 1/29/26 at 9:21 a.m., identified dressing change to surgical wound refused because was going to wound clinic and stated would perform there. R1's treatment administration record (TAR) identified a physician order1/24/26-1/29/26 to perform dressing change/wound pack to pack with 1/2 inch (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	roll gauze. Pack more gauze down towards incision and straight back twice daily and use hydrophilic wound dressing around wound for redness. Cover with ABD. Change outer dressing when saturated. The TAR indicated the dressings were changed per the order (even though Vashe was used) by checked marked boxes with no other documentation other than the nurses' initials who completed the dressing change. R1's general surgery progress note dated 1/29/26, included R1 was seen for a follow for dehisced perineal wound. R1's wound was completely dehisced at this point and extends to 4-5 cm in depth. The remaining nylon sutures were removed. The wound was only packed with a small amount of half-inch gauze which was completely saturated. This was removed and it was repacked with two pieces of dry 4x4 gauze and then covered with ABD and tape. We will relate to R1's facility how to pack the wound and will have R1 to follow up with our wound nurses for continued wound management. In review of R1's record between 1/23/26 through 1/29/26, even though R1's progress notes indicated monitoring was completed by addressing type of drainage from the wound, the documentation did not identify when the wound completely dehisced and when there had been changes to the wound size. During an observation and interview on 1/30/26 at 10:27 a.m. R1 was seated in a recliner on a pillow; however, his hips were not aligned. His right hip was positioned directly on the pillow while the left hip was elevated, resulting in increased pressure to the right side. R1 had a pressure redistribution and/or relieving cushion in his wheelchair with a pillow on top of the cushion. R1 explained he was sitting the way he was because his bottom was uncomfortable, it hurt but there was nothing anybody could do about it. Using the pillow or the cushion was not very helpful for relieving the discomfort. R1 thought he only worked with therapy but once a week. R1 reported he went to his surgeon yesterday (1/29/26), the doctor told him it would take up to two months to heal because the incision opened. When the dressing changes were done it was pretty uncomfortable. R1 stated the last several days he has had a numbing/tingling feeling going down the right leg- the doctors and nurses did not know what the cause was. During an interview on 1/30/26 at 11:09 a.m., R1 stated he was not instructed since admission to not sit on his bottom for a long period of time, until after his first surgical follow-up, R1 would have followed the instructions had he been aware. As an example of length of time sitting, R1 explained after he was admitted to the facility, every morning he would sit in his chair with a pillow on the seat for 45 minutes while he listened to the radio. R1 reiterated since his bottom opened up it was very uncomfortable and had to spend more time in bed laying on his right side. During an interview on 1/30/26 at 1:23 p.m., licensed practical nurse (LPN)-A stated she had begun to work with R1 soon after he had been admitted to the facility on [DATE]. LPN-A explained until after R1's incision began to open up she had not been aware R1 had a surgical incision and had not been aware he was supposed to stay off his bottom. LPN-A then explained she thought prior to the wound dehiscence R1 was independent, she was not aware he needed assistance and agency nursing assistants (NA's) had reported to her that R1 would refuse to reposition, however, did not know why R1 refused and did not re-approach R1 or find out reason for refusals. LPN-A indicated if a resident refused, re-approach and education should be provided. The refusals should be documented in the medical record, however, LPN-A stated there was no documentation that R1 had refused position changes. Since the wound deteriorated R1 was being prompted by staff to stay off his bottom according to the care plan. During an observation and interview on 1/30/26 at 2:30 p.m. R1 was instructed by DON to lie down in his bed to change the dressing to wound. R1 reported a pain rating 7 out of 10 (10 being the worse pain) when he sat and the pain went down into his legs. R1's rectal wound was covered by an ABD dressing dated 1/30/26. DON lifted the ABD to expose the wound cavity that had a pungent foul odor and the packed gauze which was saturated with greyish colored drainage was not to the brim of the wound leaving approximately (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1/4 to 1/2 inch of the wound not packed. DON removed the first piece of gauze from the cavity; the second piece of gauze was folded (not fluffed) covered a portion of the wound base. DON stated the gauze should have been pulled apart and the entire wound cavity packed. Inside the cavity at 2:00 O'clock to the 6:00 O'clock position was string of greyish tacky slough, DON mechanically debrided by using gauze to wipe it away. R1 voiced discomfort. DON did not rinse out the wound, re-packed the wound with two pieces of gauze so that the gauze reached the top of the wound. During an interview on 1/30/26 at 2:31 p.m., registered nurse (RN)-A stated she had been cleaning R1's rectal wound with the Vashe cleanser, however, identified the wound care orders did not give specific instructions on what it should be cleansed with. RN-A stated it had been passed on a while ago by someone to clean the wound with the Vashe, but unable to recall who gave her this instruction. RN-A could not articulate what type of cleanser Vashe was nor the indications for use. During an interview on 1/30/26 at 2:44 p.m., RN-B stated she had been cleaning R1's wound prior to repacking with the Vashe solution also that was not ordered by the physician but could not recall who had directed the instruction. RN-B could not articulate what type of cleanser Vashe was nor the indications for use. During an interview on 1/30/26 at 10:36 a.m., R1's colorectal surgeon (CR-S) indicated R1's surgical wound was at risk for dehiscence and not following the aftercare treatment orders could have contributed to the incision failure, it would not have supported healing, but no way to know for sure. CR-S would have expected the aftercare instructions be followed as written to reduce the risk of complications. CR-S stated on 1/15/26 he had seen R1 in clinic for a follow up and identified R1 rectal wound had begun to have a partial dehiscence and instructed the wound to be packed. CR-S further instructed facility staff to ensure R1 remained off of the surgical area for long periods of time. When R1 was seen on 1/29/26 the wound was completely dehisced and was not packed correctly and indicated there was no communication from the facility. The wound did not have enough packing, and it was completely saturated which could lead to wound deterioration I am not sure that the nurses in the facility had been trained properly in wound packing and had to have one of my nurses call the facility to provide some education about proper procedure for that type of wound. During an interview on 1/30/26 at 12:02 p.m., director of nursing (DON) stated she was responsible for putting new admission orders in the resident's electronic health record (EHR), however, must have missed all of the aftercare interventions R1's hospital after visit summary directed. DON added these orders on 1/14/26 but should have been added upon admission. DON stated R1's anal surgical wound should have had a comprehensive wound assessment on admission and weekly after that, however, this had not been completed until 1/15/26 (13 days after admission) after the wound had begun to open up. During a subsequent interview on 2/3/26 at 12:33 p.m., DON stated there was no documentation of monitoring that fully addressed any changes to the wound between assessments since R1 was admitted . Review of the facility's Wound Treatment Management Policy dated 12/25, identified to promote wound healing of various types, it is the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: -Wound treatments will be provided in accordance with physician orders, including cleansing methods, type of dressing, and frequency of dressing change. -In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. -the effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include lack of progression towards healing; changes in characteristics of the wound; changes in the resident's goals and preferences, such as end of life or in accordance with his or her rights.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers to /or deterioration for 2 of 3 residents (R2, R3) reviewed for pressure ulcers.?This resulted in actual harm for R2 who developed an unstageable pressure ulcer on her right heel and stage 3 pressure ulcer on sacrum. Findings include: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema (redness). Stage 2 Pressure Ulcer: Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Stage 4 pressure ulcer: Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle tendon, ligament, cartilage, or bone in the ulcer. Slough and /or eschar may be visible on some parts of the wound bed. Unstageable pressure ulcer: Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. Eschar: dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound. Slough: non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Serosanguinous drainage: is a thin, watery fluid that's often slightly yellow and has a light pink tinge that can ooze from a wound as a part of the wound healing process. Moisture Associated Skin Damage: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, sweat, wound drainage, saliva or mucus. R2 R2's face sheet dated 2/4/26, identified diagnoses of chronic kidney failure, heart failure, atrial fibrillation, and pressure ulcer of right heel. R2's admission Skin Assessment Tool dated 12/24/25, identified both heels have dry skin and a mepilex (foam dressing) on coccyx. R2's Braden Scale Assessment (Pressure Ulcer Risk) dated 12/25/25, identified R2 was at risk for pressure ulcer due to being occasionally moist, unable to make frequent/significant changes independently and had a potential problem with sheer. R2's Braden Scale Assessment did not identify any clinical suggestions to reduce development of pressure ulcers. R2's baseline care plan dated 12/25/25, identified current skin integrity issues of bruising on arms and dermatitis in pannus (apron like fold of excess skin) region. R2's baseline care plan did identify pressure reduction interventions. R2's admission Minimum Data Set (MDS) dated [DATE], identified R2 had no rejection of care, dependent for needs to roll left and right, dependent with transfers from surfaces, at risk for pressure ulcers/injuries, did not have any unhealed pressure ulcers/injuries and had a surgical wound. R2 was not on a turning and (continued on next page)

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	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Care Center	55 Tenth Street Southeast Wells, MN 56097

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F 0686 Level of Harm - Actual harm Residents Affected - Few	repositioning program, no nutrition or hydration interventions, and no dressing or treatments to feet. R2's Care Area Assessment (CAA) Worksheet signed 1/6/26, did not include a Brief Interview for Mental Status (BIMS) evaluation. MDS identified R2 had a potential problem related to pressure ulcers, related to a Braden score of 17 and at risk due to decreased mobility, obesity, need for assistance with mobility, incontinence, and oxygen use. R2's CAA identified to proceed to care plan interventions to minimize risks for pressure ulcer development. R2's Skin Issue assessment dated [DATE], did not identify any wounds on R2's right heel or coccyx. R2's progress note dated 1/9/26 at 7:00 p.m., identified R2 had a pressure area on right heel (no stage of pressure area identified). Reddened area measures 4.5 centimeters (cm) x 2.0 cm. Inside the red area is a blue moon shaped area that measured 2.5 cm x 1.5 cm. Cleansed area, applied skin prep and a mepilex (foam dressing) to area. Also put on puffy boots to protect heels. R2's heels floated. The note did not include any further descriptions of the wound characteristics. R2's progress note dated 1/9/26, identified a message sent to physician requesting order for Liquacel (protein supplement) and Arginaid (powered drink to support wound healing) for wound healing. R2's Incident report dated 1/9/26, identified R2's legs were swollen and upon inspection an unstageable pressure ulcer found on R2's right heel. Immediate action to measure area and puffy boots applied to area. R2's provider notification form dated 1/10/26, identified the facility requested an order for puffy boots for protection due to an unstageable pressure ulcer to right heel that had applied mepilex and puffy boots. Measurements of 4.5 cm x 2.0 cm. R2's skin integrity focus care plan initiated on 1/11/26 (two days after identification of the heel ulcer), identified R2 had a potential/actual impairment to skin integrity of the right heel related to a suspected deep tissue injury. Goal to free from deep tissue injury to right heel. Interventions dated 1/11/26 as follows: -Educate resident/family/caregivers of causative factors and measures to prevent skin injury. -Follow facility protocols for treatment of injury. -Keep linen clean, dry, and wrinkle free. Lowest possible head of bed elevation maintained. No shoes only gripper socks until heel wound healed. -Report any signs of skin breakdown. -Pressure relieving/reducing mattress, pillows. Prevalon (boots that have a cushioned bottom that floats the heel off a surface) heel relieving pressure boots to protect skin while in bed and recliner and in wheelchair. -Turn and reposition every 2 hours and as requested to relieve all pressure points, using pillows between legs and along back while in bed and float heels. -Usa a draw sheet or lifting device to move resident. -Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. -Use pressure reducing cushion in wheelchair and pressure reducing mattress on bed. Resident sits in personal recliner as needed. In review of R2's record between 12/24/25 through 1/11/26 did not include a comprehensive assessment that determined R2's tissue tolerance to pressure over time and it could not be ascertained how the turning and repositioning of every 2 hours was determined. R2's provider notification form dated 1/11/26, identified an order request to apply skin prep to right heel twice daily to the pressure area on the right heel. R2's physician communication dated 1/12/26 at 9:19 a.m., identified physician order received for puffy boots to be worn for heel protection. R2's physician communication dated 1/12/26 at 9:32 am., identified message sent (to the physician) that R2 was no longer using mepilex dressing due to got too moist and will apply skin protectant and leave open to air and monitor for changes and Prevalon heel protectors are the boots not puffy boots. Although the communication identified a change to the heel wound, R2's record did not include a corresponding comprehensive assessment. R2's physician communication dated 1/12/26, identified an order was received for skin protectant twice daily and Prevalon boots for heel protection. Treatment approved and may change per licensed nurse discretion as needed, please notify any new/worsening conditions. (continued on next page)

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	245436	A. Building B. Wing	02/05/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's physician orders dated 1/12/26, identified an order for skin protectant to right heel and monitor for healing progression and symptoms of infection every day. R2's Wound assessment dated [DATE], identified R2 had a new stage 1 pressure ulcer to right lateral heel that measured 2.95 cm x 2.77 cm that had dry flaky skin; was normal in color; no edema present. During an interview on 2/3/26 at 2:12 p.m., director of nursing (DON) reviewed R2's corresponding image from 1/13/26 of R2's and identified the assessment as inaccurate. R2's right heel did not have normal color (was dark purple in color) and should have been identified as a deep tissue injury not a stage 1 pressure ulcer. R2's Wound assessment dated [DATE], identified a new wound of an open lesion on the coccyx. Measurement of 5.4 cm x 0.98 cm with 40% epithelial tissue, 40% granulation, and 20% slough; surrounding tissue excoriated (a superficial, partial thickness skin erosion); fragile; treatment of hydrogel and foam dressing. R2's record did not include an order for this treatment. During an interview on 2/3/26 at 2:12 p.m., DON stated R2's Wound Assessment was inaccurate and was identified as an open lesion when it should have been identified an unstageable pressure ulcer to R1's sacrum not coccyx. R2's Wound Care Clinic note dated 1/15/26, identified R2 was seen for consultation for coccyx pressure ulcer. Clinic note identified R2 had a stage 3 sacral pressure ulcer that measured 1.5 cm x 0.7 cm x 0.1 cm. and required debridement (the medical removal of dead, managed, or infected tissue) of devitalized tissue to facilitate healing. Recommendation of a good cushion for wheelchair to prevent skin breakdown. Check lower extremities/feet daily for new wound. Do not walk barefoot/stocking feet. Do not use band-aid on skin unless recommended by provider. Turn and reposition every 1-2 hours and as needed to help prevent skin breakdown. The wound clinic note did not address the right heel pressure ulcer. After R2's wound clinic visit on 1/15/26 there was no indication R2's turning and repositioning schedule reassessed to determine effectiveness of the existing every two hour repositioning program identified in the care dated 1/11/26. R2's physician orders dated 1/16/26, identified an order to wash hands, remove old dressing, cleanse wound bases with Vashe (a hypochlorous acid solution designed for cleansing, irrigating, moistening, debriding, and removing foreign material) or house wound cleanser; apply Plurogel (to wound base; cover with foam bordered dressing; change once daily to coccyx wound. R2's Wound assessment dated [DATE], identified R2 had a stage 1 pressure injury to right lateral heel that was first identified on 1/13/26. Measurements of 2.2 cm x 1.99 cm with no eschar; no drainage; was dry and flaky; cleansed with normal saline; getting mechanical debridement. It had 100% epithelial tissue. During an interview on 2/3/26 at 2:12 p.m., DON reviewed the assessment with corresponding picture of the wound and stated R2's Wound Assessment was inaccurate and should have been identified as a deep tissue injury not a stage 1 pressure ulcer, had four open areas to the wound, and did not have any epithelial tissue. R2's Wound assessment dated [DATE], identified an open lesion on coccyx that was improving; measured 2.12 cm x 1.02 cm; surrounding tissue intact with no drainage. R2's pressure ulcer focus care plan initiated on 1/20/26, identified R2 had an unstageable pressure ulcer on her right heel and a stage 3 pressure ulcer on her coccyx. Goal of having intact skin, free of redness, blisters, or discoloration. Interventions dated 1/20/26 as follows: -Administer treatments as ordered and monitor for effectiveness. -Equacel (a dry -polymer gel cushion designed for pressure management) cushion on wheelchair for pressure redistribution. Air mattress on bed. -Repositioning-has schedule under tasks to assist in turning and repositioning. - The resident requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. Arginaid and Liquacel BID. R2's wound management care plan of pressure ulcer on heel initiated on 1/23/26, identified goal of wound to show signs of improvement. Interventions dated 1/23/26 as follows: -Encourage resident to elevate legs. -Evaluate ulcer characteristics. -Measure ulcer at regular intervals. (continued on next page)

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	245436	A. Building B. Wing	02/05/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Monitor ulcer for signs of infection. -Monitor ulcer for signs of progression or declination. -Notify provider if no signs of improvement on current wound regime. -Provide wound care per treatment orders. R2's Wound assessment dated [DATE], identified an unstageable pressure ulcer that presented as a deep tissue injury that was first identified on 1/13/26 (however was first identified on 1/9/26). Measurement of 4.0 cm x 2.0 cm; had intact skin surrounding wound; no dressing; no drainage; treatment of skin protectant. During an interview on 2/3/26 at 2:12 p.m., DON reviewed wound assessment and corresponding image of R2's right heel on 1/27/26 and stated R2's Wound Assessment was inaccurate and did not identify the open areas and the wound with whitish areas in the center. R2's Wound assessment dated [DATE], identified stage 2 pressure ulcer on coccyx; had 100% slough; measurements of 0.27 cm x 0.17 cm; minimal drainage; receiving Vashe wound cleanser and covered with silicone dressing. During an interview on 2/3/26 at 2:12 p.m., DON stated R2's 1/27/26 sacral wound assessment was inaccurate because the wound clinic identified it as stage 3 pressure ulcer on the sacral wound (not coccyx) and should have remained as stage 3 until it was healed. During an observation and interview on 1/30/26 at 4:47 p.m., R2 was seated in her wheelchair in her room with leg rest on her wheelchair, had gripper socks on both feet. R2's right heel was resting directly on the metal part of the pedal of the leg rest. R2 did not have Prevalon boots on and stated her right heel was sore. R2's right heel had a purple discoloration on her right lateral heel approximately 4.0 cm x 2.0 cm in size. R2 then stood up on a sit to stand mechanical lift and there was no dressing (as per physician order) on the coccyx/sacral area. R2 had an open area on the sacral area approximately 0.5 cm x 0.5 cm. NA-D stated she was unaware if R2 was supposed to have the Prevalon boots on when she was in her wheelchair and believed it was only when she was in her recliner or in bed. During an interview on 1/30/26 at 5:15 p.m., DON stated R2 should have a dressing on her coccyx/sacral area per physician order and heel protectors placed on if her feet if the foot pedals were on her wheelchair to help relieve pressure to the heels. DON stated she would update the care plan. R2's care plan had been revised on 1/30/26 to blue heel floating boots on when in bed; heels floated on pillow when in bed and in recliner; do not wear shoes or tight stocking on right foot to prevent pressure until healed. Wear Prevalon heel boots when in wheelchair when foot pedals are on wheelchair. R2's January 2026 Treatment Administration Record (TAR) identified a physician order dated 1/12/26 for skin protectant to right heel and monitor for healing progression and symptoms of infection every day. R2's TAR identified treatment was not completed on 1/22/26, 1/27/26, and 1/30/26. R2's January TAR identified the physician order dated 1/16/26 to wash hands, remove old dressing, cleanse wound bases with Vashe or house wound cleanser; apply Plurogel to wound base; cover with foam bordered dressing; change once daily to coccyx wound. TAR indicated that treatment was not completed on 1/27/26 and 1/30/26. During an observation and interview on 2/3/26 at 10:16 a.m., R2 was seated in her room seated in her wheelchair. R2's wheelchair did not have leg rests on. R2's wheelchair had a cushion on the seat; however, the cushion was hanging approximately 8 inches in front of the seat. R2 stated This cushion has been slipping out from under my bottom all of the time. NA-E entered R2's room and offered place R2 on the commode. As R2 stood the Equagel cushion was only under about 4 inches of her bottom, and the rest of her buttocks were seated on the wheelchair seat with no pressure reduction present. Nursing assistant NA-E stated R2's cushion needed an antiskid pad under the cushion to ensure it did not slip out from under R2. The placement of the cushion was not providing pressure reduction. NA-E then stood R2 up to use the commode and pulled her pants down. R2's coccyx/sacral area did not have a dressing over the open area (as per physician order). NA-E stated she was not aware if the nurses had been putting a dressing over the area and did not recall seeing one. NA-E indicated she was assigned to care for (continued on next page)

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	245436	A. Building B. Wing	02/05/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2 today (2/3/26) and was unable to articulate if R2 was on a turning and repositioning schedule. During an interview on 2/4/26 at 11:35 a.m., registered dietician (RD) stated she was consultant for the facility and would normally review nutrition needs for residents with pressure ulcers, to ensure a supplement was added to promote wound healing. RD stated she had not been informed of R2's pressure ulcers and did not make any recommendations. During an interview on 2/5/26 at 10:34 a.m., nurse practitioner (NP) stated if a resident was admitted to the facility without a pressure ulcer and identified as a high risk for developing pressure ulcers then interventions should be put in place to attempt to prevent a pressure ulcer from developing. R3 R3's face sheet dated 1/30/26, identified diagnoses of hemiplegia and hemiparesis following cerebral infraction, heart failure, and atrial fibrillation. R3's MDS dated [DATE], identified R3 had moderate cognitive impairment, had no rejection of care, dependent to roll left and right, dependent for transfers from surfaces. R3 was at risk for pressure ulcers/injuries but did not have any unhealed pressure ulcers/injuries. Skin and Ulcer/Injury treatments included pressure reducing devices for chair and bed and applications of ointments/medications other than to feet. R3's Braden Pressure ulcer risk dated 1/13/26, identified as high risk for pressure ulcer due to having slightly limited to sensory perception, being constantly moist, was chairfast, and completely immobile for mobility, and very poor for nutrition. R3's skin integrity care plan initiated 9/15/22, identified R3 had potential for skin impairment related to fragile skin. Goal that skin will remain clean and intact. Interventions dated 9/15/22 as follows: -Assess resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. -Encourage resident to be mindful of surroundings when self-propelling in his wheelchair to avoid injury. -Keep linens clean, dry, and wrinkle free. Lowest possible head of bed elevation maintained. -Keep skin clean and dry. Use lotion on dry skin. -Report any signs of skin breakdown. -Use pressure reducing cushion in wheelchair and pressure reducing mattress on bed. R3's hospital Discharge summary dated [DATE], identified R3 had been hospitalized [DATE] through 1/13/26 following a stroke. R3's progress note dated 1/13/26 at 12:00 p.m., identified nurse to nurse report was given due to R3 being re-admitted to facility from the hospital. Hospital nurse reported R3's heels a little red and the hospital had been repositioning and floating heels. R3's readmission skin assessment dated [DATE], did not identify any open areas to bilateral heels. R3's skin integrity care plan was revised on 1/13/26 to turn and reposition every 2 hours and as requested to relieve all pressure points, using pillows between legs and along back while in bed and float heels on pillows to protect the skin while in bed. Heel protector boots on when in bed. The review of R3's record did not include a comprehensive assessment that determined R3's tissue tolerance to pressure over time and it could not be ascertained how the turning and repositioning of every 2 hours was determined identified in the care plan dated 1/13/26. R3's Skin Assessment Tool dated 1/18/26, identified R3 had an open area on right heel, area cleansed, and skin prep and dressing applied. Although R3's Skin Assessment Tool identified a skin prep treatment and a dressing had been applied, the assessment did not specify what type of dressing used and there was no corresponding physician order. R3's Skin Issue assessment dated [DATE], identified a new skin issue on right heel. It was a blister that already reabsorbed the fluid. Wound was acquired in house and was painful. Measured 1.14 cm x 1.47 cm. The skin assessment did not include any other wound characteristics. R3's corresponding image of R3's right heel dated 1/19/26, identified R3's heel was red in color and had blister that had not fluid present in it. At the top of the wound had red material and the wound had an irregular shape. Area was macerated in nature. Heel appeared shiny. R3's hospice admission note dated 1/19/26, identified R3 right heel had a 1.0 cm x 1.5 cm blister that had peeled off and was covered with non-adherent dressing and tape. Ensure heels are (continued on next page)

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	245436	A. Building B. Wing	02/05/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	floated. Treatment order dated 1/19/26 included to cleanse with soap and water, pat dry, and apply mepilex change weekly with bath and as needed. R3's physician orders did not include any treatments to R3's heel as identified in the hospice note dated 1/19/26 until 1/21/26. -Right heel cover with bordered gauze dressing to protect until resolved once daily (Start on 1/21/26 through 1/21/26) -Right heel cleanse with saline apply skin protectant and cover with bordered gauze dressing to protect until resolved once daily (Start on 1/22/26 through1/23/26) -Wound care to right lateral heel twice weekly with baths and as needed. Cleanse open blister with soap and water and dry with towel. Cover with mepilex and re-evaluate with every dressing change. Every Wednesday and Sunday. (Start 1/25/26) R3's Wound assessment dated [DATE], identified a blister on the right lateral heel. Additional information was that blister that had already reabsorbed the fluid. Wound identified as stable; in-house acquired; measurements of 1.14 cm x 1.9 cm; light serous drainage with foam dressing as treatment. R3's corresponding image of R3's right heel wound dated 1/27/26, identified an open blister that encompassed the lateral heel and extended to the back of heel. Wound edges were irregular in shape, and the base of the wound was red skin under the blister. Heel appeared shiny in color. During an interview on 2/3/26 at 2:12 p.m., DON stated R3's right heel wound assessment completed on 1/27/26 was inaccurate and the image appeared like the wound had worsened since the last assessment and should have ensured R3's heels were floated properly. During an observation and interview on 1/30/26 at 11:16 a.m., R3 was lying in bed with a pillow under both legs and had heel protectors on both heels. R3's right heel was resting directly on the air mattress. Hospice registered nurse (H-RN) stated R3's heel should not be resting on the bed to ensure pressure is relieved. H-RN then removed a foam dressing off R3's right heel and stated the lateral heel had a stage 2 pressure ulcer that measured 1.0 cm x 1.7 cm. R3's back of his heel had a new stage 2 pressure ulcer measuring 1.5 cm x 1.0 cm. H-RN stated this was caused by incorrect repositioning and not ensuring R3's heel was floated off the bed. This would be considered avoidable and will continue the same treatment to the right heel for the second wound. Review of the facility's Pressure Injury Prevention and Management Policy dated 5/25, identified the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injury. Policy Explanation and Compliance Guidelines: -The facility shall establish and utilize a systemic approach for pressure ulcer injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and document review the facility failed to ensure proper handwashing/hand hygiene was implemented for 1 of 3 residents (R4) observed for handwashing/hand hygiene during wound care. Findings include:R4's face sheet dated 2/4/26, identified diagnoses of chronic venous hypertension with ulcer, congestive heart failure, diabetes mellitus with foot ulcer, and atrial fibrillation. R4's Baseline Care Plan dated 1/30/26, identified R2 had venous stasis ulcer to bilateral lower extremities. R4's hospital after visit summary dated 1/28/26, identified R4 had orders for wound care to bilateral lower extremities to cleanse with normal saline or wound cleanser, apply nonadherent dressing to any open areas, cover with ABD pads, and secure with Kerlix. R4's physician orders dated 1/29/26, identified an order to bilateral lower extremities to cleanse with normal saline or wound cleanser, apply nonadherent dressing to open areas then cover with ABD pads and secure with kerlix. During an observation and interview dated 1/30/26 at 10:23 a.m., assistant director of nursing (ADON) performed wound care to R4's bilateral lower extremities. ADON had a gown and gloves on and began removing a dressing off R4's left leg, placed the dressing in the garbage, then proceeded to grab a wound cleanser bottle without removing glove or performing hand hygiene. ADON then proceeded to spray the ulcer and then grabbed gauze and patted the wound with the gloved hand. ADON then removed her gloves and applied a new pair of gloves without performing hand hygiene prior to applying the gloves on. ADON then removed the dressing off the right leg and placed the dressing in the garbage. ADON stated she does not need to perform hand hygiene until she is completed the entire dressing change and stated, How am I supposed to do hand hygiene in between when there is not hand sanitizer in the room. During an interview on 2/4/26 at registered nurse at 11:00 a.m., registered nurse infection preventionist (RN-IP) stated hand hygiene should be done prior to entering a resident room, before applying gloves, in between glove changes, and should be done if touching anything considered soiled such as cleaning a wounds and should be done before touching clean wound supplies. Review of the facility's Hand Hygiene Policy dated 11/11/25, identified all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Additional considerations: The use of gloves does not replace hand hygiene. If a task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand hygiene should be done after handling items potentially contaminated with blood, body fluids, secretions, or excretions.