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	04/07/2026

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. The facility failed to maintain complete and accurate accounting records of resident personal funds for 10 of 10 residents (R17, R18, R19, R20, R21, R22, R23, R12, R9, R11) whose funds were maintained in a commingled facility trust account. Findings include:The facility provided resident trust statements for all the residents who had given the facility to manage. The trust statements only had the balance with no accounting of credits or debits from the account. Further the trust statements did not identify and/or account for interest earned if any. R17's trust statement dated 4/3/26, identified a balance of $94.73.R18's trust statement dated 4/3/26, identified a balance of $85.00.R19's trust statement dated 4/3/26, identified a balance of $1,899.11.R20's trust statement dated 4/3/26, identified a balance of $100.00.R21's trust statement dated 4/3/26, identified a balance of $349.00.R22's trust statement dated 4/3/26, identified a balance of $100.00.R23's trust statement dated 4/3/26, identified a balance of ($15.00). This indicated the balance was negative.R12's trust statement dated 4/3/26, identified a balance of $45.00.R9's trust statement dated 4/3/26, identified a balance of $77.00.R11's trust statement dated 4/3/26, identified a balance of $58.00.The facility checking account statement ending 1/30/26, identified a beginning balance on 1/1/26, of $5,315.53 and ending balance of $5,125.53. On 1/2/26, a deposit was made under R17's name. The statement did not account for any other resident debits or credits. The facility checking account statement ending 2/27/26, identified a beginning balance on 1/31/26, of $5,125.53 and ending balance of 5028.96. On 2/3/26, a deposit was made under R17's name for $1,145.00. The statement did not account for any other resident debits or credits. The facility checking account statement ending 3/31/26, identified a beginning balance on 2/28/26, of $5,028.96 and ending balance of 4700.02. On 3/3/26, a deposit for $1,145.00 was made under R17's name. The statement did not account for any other resident debits or credits.The facility Business Savings account statement ending 12/31/25, identified a balance of $401.53. Interest earned from 10/1/25-12/31/25 was $0.05 with a year-to-date interest balance of $0.20.The facility Business Savings account statement ending 3/31/26, identified a balance of $401.53. Interest earned was $0.05, bringing the balance to $401.58.During an interview on 4/2/26 at 3:14 p.m., activity director (AD)-A stated she manages the funds for seven residents. AD-A does not have access to the account and it is a non-interest bearing account. AD-A manages the accounts by paying for items monthly for residents such as haircuts. AD-A pays the hairdresser with checks she has and then gives them to the Administrator. Within the electronic record facility there is an area to record deposits and withdrawals. AD-A was unaware how to record this information, so the information does not match the actual bank statements. AD-A prints off the balances from the electronic record and mails them to families every three months.During an interview on 4/7/26 at 10:28 a.m., Administrator stated the business office (BO)-A at a sister facility managed the trust accounts. BO-A deposits the money in savings and when funds are needed transferred them to checking. Administrator acknowledged the bank statements identified R17 was the only resident represented on the bank statement. Administrator acknowledged the facility needed education on how to track and deposit resident funds with a ledger which identified each individual residents expenditures.

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to notify the physician of recurrent refusals of physician ordered medication for 1 of 1 residents (R21) who required lactulose for treatment and management of constipation and hepatic failure/alcoholic cirrhosis. Findings include R21's face sheet dated 4/3/26, identified diagnoses of chronic hepatic failure without coma, and alcoholic cirrhosis of liver without ascites.R21's quarterly Minimum Data Set (MDS) dated [DATE], identified R21 had no cognitive impairment. R21 rejected cares 1-3 days.R21's care plan dated 9/4/25, identified R12 had diagnoses of constipation and is at risk for constipation when refuses medication for constipation, is receiving laxatives-Lactulose and MiraLAX for management related to diagnoses of cirrhosis of liver. Will refuse other medications for bowels. Interventions included administer medications as ordered. Document if he refuses. Encourage R21 to sit on toilet to evacuate bowels if possible. Follow facility protocol for bowel management. Document if R21 refuses to follow protocol to help evacuate bowels. R21's care plan dated 1/26/26, identified R21 can be resistive to cares. Often refuses medications and hygiene. Interventions included to allow R21 to make reasonable decisions about treatment regime to provide sense of control.R21's physician orders signed 3/19/26, identified an order for Lactulose. Give 45 milliliters (ml) by mouth three times a day related to hepatic failure.R21's medication administration record (MAR) dated 3/2026, identified Lactulose scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m. All administrations reviewed from 3/1/26-3/31/26, identified R21 was administered only 19 doses of the physician ordered lactulose of 93 doses that were ordered. R21's Provider Notification Form dated 3/18/26, identified R21 continued to refuse medications. Medical doctor (MD)-A replied he would address on nursing home rounds.R21's physician visit note dated 3/19/26, did not identify or address R21's medication refusals as per the provider notification.R21's MAR dated 4/2026, identified Lactulose scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m. All administrations reviewed from 4/1/26-4/7/26 at 8:00 a.m., were signed with a 2, which indicated drug refused.Review of R21's progress notes for 4/2026, did not identify and/or address R21's lactulose refusals nor evident physician was notified of R21's refusals.During an interview on 4/3/26 at 1:21 p.m., trained medication aide (TMA)-A stated if a resident refused a medication, the nurse needed to be notified right away. TMA-A was unable to articulate why R21 took Lactulose and what staff should monitor for when he refused it.During an interview on 4/3/26 at 1:39 p.m., licensed practical nurse (LPN)-A stated R21 took Lactulose for chronic constipation. R21 would refuse a lot and would need coaxing to take medication. If medications were refused for three days the doctor should be notified. LPN-B could not find anything in R21's care plan for the management of hepatic failure/cirrhosis aside from bowel management and was unable to articulate R21's risks associated with the diagnosis of hepatic failure/cirrhosis and unable to identify appropriate associated monitoring systems for sign/symptoms of worsening condition. During an interview on 4/3/26 at 3:03 p.m., registered nurse (RN)-B stated R21 took Lactulose for an alcoholic liver. R21 refused medications often. Physician should be notified right away of refusal of medications through the Physician Notification Form; education and explanation of the need to take medication should be provided to R21, along with writing a progress note.During an interview on 4/7/26 at 9:36 a.m., director of nursing (DON) was unaware if staff had been documenting refusals of medications in the progress notes recently but knew it had been done in the past. DON did not realize R21 did not have a care plan regarding cirrhosis of liver.The facility Notification of Changes policy revised 12/2025, identified the facility promptly informs the resident, consults the residents physician, and notifies, consistent with his or her authority, the residents representative when there is a change requiring notification.The facility abuse policy was requested on 4/2/26 at 3:02 p.m. but not received.

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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 behavioral care plan after resident-to-resident altercation for 1 of 1 resident (R11) reviewed for abuse. In addition, the facility failed to revise the care plan to reflect ongoing pattern of medication refusals for 1 of 1 resident (R21) who was prescribed a clinically significant medication used to treat a diagnosis of cirrhosis/hepatic failure. Findings include:R11's face sheet dated 4/2/26, identified diagnoses of Alzheimer's disease with late onset, anxiety disorder, mild cognitive impairment, and blindness of right eye.R11's physician order dated 6/12/24, identified to monitor and note behavior in progress note of irritability, verbal aggression, stating he feels down or blue, not visiting with others, walking the halls, and not eating.R11's physician order dated 6/8/25, identified to check R11's room daily for weapons such as scissors, knives, forks, etc. after recent episodes of aggression.R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had some difficulty with hearing and speech clarity. R11 was rarely understood and had severe cognitive impairment. R11 had inattention and disorganized thinking. R11 had behavioral problems which included physical behavioral symptoms directed towards others and verbal behavioral symptoms directed towards others. R11 rejected care and wandered 1-3 days. R11 was independent with a wheelchair.R11's care plan dated identified, R11 exhibited a behavior of inappropriate touching of females dated 5/28/24 with associated interventions that included administer medication as ordered; caregivers provide opportunity for positive interaction and attention; Stop and talk to R11 when passing by; Intervene as necessary to protect the rights and safety of others; Approach/speak in a calm manner. Divert attention; Remove from situation and take to alternate location as needed; Monitor behavior episodes and attempt to determine underlying cause; Monitor R11's whereabouts when his room entry motion sensor alarm goes off to see if his is leaving his room to monitor where he is going; Social service designee will discuss behavior with resident and explain/reinforce why it is inappropriate and/or unacceptable to touch other residents, especially females inappropriately one day every week.R11's care plan dated 6/1/25, identified R11 had incidents of verbal aggression with resident 1120. R11 had been asked to move tables in the dining room and refused. R11 and resident 1120 get along much of the time. Interventions included analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Do not wake R11 when sleeping as this can agitate him. Monitor/document/report as needed any signs/symptoms of R11 posing danger to himself and others. Staff to monitor R11's whereabouts and what he is doing when out of his room and around resident 1120. If able, try and get R11 to leave situation. If it is mealtime, tell R11 he can come back in a little while.R11's progress note dated 12/29/25 at 10:26 a.m., identified R11 had been agitated all day. At 8:30 a.m., R11 was outside of his room, in hallway and another resident walked by. R11 swung at the other resident. The other resident ducked. R11 did not make contact with his fist on the other resident. Staff members observed and went to residents. Went to R11's room and he pointed at his bed which appeared wet. Wondered if R11 thought the other resident had wet his bed. The other resident appeared frightened. It was also reported that when nursing staff was assisting R11 to the breakfast table, he hit out at another resident sitting next to him but did not make contact. Later in the morning, the other resident that R11 had previously struck out at, was in the dining room. R11 went up to the resident and was mumbling in anger. The other resident was frightened and put his arms up and walked away from R11 to the other side of the dining room without his walker because R11 was close to the walker. Staff intervened and got the other resident his walker.In review of R11's record it was not evident care plan interventions were evaluated for effectiveness after the incident and R11's care plan did not identify the new aggression toward another resident and staff nor new interventions to manage the behaviors R11 displayed on 12/29/25.During an observation on 4/2/26 at 1:19 p.m., R11 was in his room. R11's room (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was located on the opposite side of facility as R12.During an interview on 4/2/26 at 1:20 p.m., nursing assistant (NA)-D stated R11 was both aggressive and not aggressive depending on time of day and approach. NA-D had never seen R11 aggressive towards residents, only staff. R11 would kick and hit at staff. NA-D tried to maintain a healthy distance away from R11 if R11 was being aggressive. NA-D would allow R11 to calm down before reapproaching for cares if he was aggressive. NA-D was unaware of incident between R11 and R12 in December.During an interview on 4/2/26 at 1:25 p.m., NA-B stated R11 could be aggressive but had never witnessed aggression towards other residents. R11 would show aggression to staff if NA's woke him up before he wanted to get up, when that would happen it would affect R11's whole day. R11 would be upset and chase the NA's around the facility. R11's Kardex identified to intervene as necessary, to protect and approach in calm manor, remove from situation, and take to an alternate location as needed. NA-B stated she would intervene before R11's agitation escalated, engage calmly in conversation and approach later if needed.During an interview on 4/7/26 at 9:36 a.m., director of nursing (DON) stated after the incident on 12/29/25, R11 and R12 were separated from each other and asked to stay away from each other as much as possible. DON did not revise R11's care plan interventions after the altercation to identify aggressive/agitative behaviors toward R12 and staff. Root cause of incident was that R11 did not know or realize what he was doing. R21's face sheet dated 4/3/26, identified diagnoses of chronic hepatic failure without coma, and alcoholic cirrhosis of liver without ascites.R21's care plan dated 9/4/25, identified R12 had diagnoses of constipation and is at risk for constipation when refuses medication for constipation, is receiving laxatives-Lactulose and MiraLAX for management related to diagnoses of cirrhosis of liver. Will refuse other medications for bowels. Interventions included administer medications as ordered. Document if he refuses. Encourage R21 to sit on toilet to evacuate bowels if possible. Follow facility protocol for bowel management. Document if R21 refuses to follow protocol to help evacuate bowels. Provide pericare after each incontinent episode.R21's care plan dated 1/26/26, identified R21 can be resistive to cares. Often refuses medications and hygiene. Interventions included to allow R21 to make reasonable decisions about treatment regime to provide sense of control.R21's quarterly MDS dated [DATE], identified R21 had no cognitive impairment. R21 rejected cares 1-3 days.R21's physician orders signed 3/19/26, identified an order for Lactulose. Give 45 milliliters (ml) by mouth three times a day related to hepatic failure.R21's medication administration record (MAR) dated 3/2026, identified Lactulose scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m. All administrations reviewed from 3/1/26-3/31/26, with only 19/93 administrations administered.R21's Provider Notification Form dated 3/18/26, identified R21 continued to refuse medications. Medical doctor (MD)-A replied he would address on nursing home rounds.R21's physician visit note dated 3/19/26, did not address the medication refusals as indicated by the physician notification form dated 3/18/26. R21's MAR dated 4/2026, identified Lactulose order which was scheduled at 8:00 a.m., 2:00 p.m., and 8:00 p.m.; 19 of possible 19 administrations reviewed from 4/1/26 through 4/7/26 at 8:00 a.m., were signed with a 2, which indicated drug refused.Review of R21's progress notes between 4/1/26 through 4/7/26 did not include follow-up and/or address R21's refusals of Lactulose. R21's record reviewed between 3/4/26 through 4/7/6 revealed even though R21 had ongoing refusals of lactulose (74 doses) according to March 2026 MAR, April MAR and R21's Provider Notification Form dated 3/18/26, that identified R21 continued to refuse medications there was no indication the care plan for refusals was reviewed and evaluated for effectiveness and updated to address R21's treatment needs, associated risks (i.e.- encephalopathy), patterns of the refusals and individualized interventions to manage the behavior. During an interview on 4/3/26 at 1:21 p.m., trained medication aide (TMA)-A stated if a resident refused a medication, the nurse needed to be notified right away. TMA-A was unable to articulate why R21 took Lactulose and what staff should monitor for when he refused it.During an interview on 4/3/26 at 1:39 p.m., licensed practical nurse (LPN)-A stated R21 took Lactulose for chronic constipation. R21 would refuse a lot and would need coaxing to take medication. If medications were refused for three days the doctor should be (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified. LPN-B could not find anything in R21's care plan for the management of hepatic failure/cirrhosis aside from bowel management and was unable to articulate R21's risks associated with the diagnosis of hepatic failure/cirrhosis and unable to identify appropriate associated monitoring systems for sign/symptoms of worsening condition. During an interview on 4/3/26 at 3:03 p.m., registered nurse (RN)-B stated R21 took Lactulose for an alcoholic liver. R21 refused medications often. Education and explanation of the need to take medication should be provided to R21, along with writing a progress note.During an interview on 4/7/26 at 9:36 a.m., DON was unaware if staff had been documenting refusals of medications in the progress notes recently but knew it had been done in the past. DON did not realize R21 did not have a care plan regarding cirrhosis of liver.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed ensure comprehensive assessments for appropriate sling sizes for full body mechanical lift according to manufacturer guidelines to ensure safe transfers to mitigate the risk of injury for 2 of 2 residents (R16, R10) reviewed for safety.Findings include:R16R16's face sheet dated 4/2/26, identified diagnoses of encounter for closed fracture with routine healing, and muscle weakness.R16's admission MDS dated [DATE], identified R16 had severe cognitive impairment. R16 was dependent on staff for dressing, rolling, and transfers. R16 did not move from sitting to lying, lying to sitting, or sitting to standing.R16's Baseline Care Plan dated 2/5/26, identified R16 required staff assistance to transfer but did not identify how the transfer would be accomplished.R16's care plan dated 3/3/26, identified R16 required a mechanical lift with assist of two people for transfers. R16's care plan did not identify sling size to use prior to start of survey. During an observation on 4/2/26 at 9:05 a.m., R16 was in bed. R16's mechanical lift sling tag had the printing dissolved and unable to read the sling size.During an observation on 4/2/26 at 10:50 a.m., licensed practical nurse (LPN)-A and nursing assistant (NA)-A transferred R16 with the unmarked sling and mechanical lift from bed to wheelchair.During an interview on 4/2/26 at 11:10 a.m., NA-A stated NA's decide what sling to use by resident weight. R16 was a medium sling based on weight which had brown straps. The slings used to say what size they were, but they have become worn from washing. The Kardex should include what size sling to use with the lifts. NA-A reviewed R16's and R10's Kardex and verified neither had a sling size identified on the Kardex. NA-A went to the linen closet and identified a sign from the mechanical lift company that stated small slings that had gray straps were for 70-100 pounds, beige straps for medium sling with weight 90-220 pounds, burgundy straps for large with weight 190-320 pounds, and extra-large green straps with weight 280-450 pounds. The signage also included measurements from base of neck to tailbone. Small 21 inches, medium 24 inches, large 26 inches, and extra-large 28 inches. NA-A did not acknowledge the measurement of neck to tailbone in the calculation for sling size when she determined what sling to use. NA-A then reported to LPN-A that R10's and R16's Kardex did not include what size sling to use. During an interview on 4/2/26 at 1:53 p.m., RN-A provided a Comprehensive Assessment for Sling Sizing she had just created. The facility would begin utilizing this immediately.In review of R16's record, there was no indication of a completed comprehensive assessment to determine sling size prior to the start of the survey on 4/2/25. R16's record on 4/2/26 included a completed Comprehensive Assessment for Sling Sizing for Total Lift dated 4/2/26, identified R16 weighed 101.9 pounds and measurement from base of neck to tailbone was 22 inches. R16's sling size was medium.On 4/2/26, R16's care plan was updated to include use of medium mechanical lift sling.R10's face sheet dated 4/2/26, identified diagnoses of spinal stenosis (narrowing of spaces within the spinal canal), lumbago with sciatica on left and right side (pain in lower back and legs due to nerve compression), and age-related physical debility.R10's quarterly Minimum Data Set (MDS) dated [DATE], identified R10 had no memory issues. R10 was dependent on staff for dressing, rolling side to side, sitting to lying, sitting to standing, chair/bed transfers.R10's care plan revised 8/18/25, identified R10 required a (full body) mechanical lift with two staff assist for all transfers. R10's care plan did not identify the size of sling to use with the liftIn review of R10's record, there was no indication of a completed comprehensive assessment to determine sling size prior to the start of the survey on 4/2/25. R10's record on 4/2/26 included Comprehensive Assessment for Sling Sizing for Total Lift dated 4/2/26, identified R10 weighed 143.3 pounds and measurement from base of neck to tailbone was 22 inches. R10's sling size was medium.R10's Kardex dated 4/2/26, identified R10 transferred with the mechanical lift using a medium sling.During an interview on 4/2/26 at 1:25 p.m., NA-B stated sizes of the sling are on the slings. Each sling has a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight limit and the sign in the linen closet would tell them what size sling to use based on weight.During an interview on 4/2/26 at 3:10 p.m., NA-C stated she was unsure how to determine what size of sling to use on residents but if they are bigger get a large, if smaller get a small. NA-C thought the sling sizes would be included on residents Kardex.During an interview on 4/2/26 at 11:21 a.m., RN-A stated sling sizes should be in the care plan and Kardex. NAs cannot choose size of sling. Sizing of slings should be completed by therapy or nursing department. Sizing would be determined by measuring from neck to tailbone and current weight of resident. RN-A expected the sling sizes to be included in the care plan and Kardex for staff.During an interview on 4/7/26 at 9:36 a.m., DON stated staff are trained on mechanical lift upon hire. The NA's are able to train staff on mechanical lifts. DON measured sling sizes for residentsThe facility Safe Resident Handling/Transfers undated, identified the facility will ensure that there are appropriate amounts of varying sizes of slings to accommodate residents and that residents will be measure correctly as per the manufacturer's instructions on proper sling size.The EZ Way Smart Lift Operators Instructions undated, identified for safe operation, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients. As patients vary in size, shape, weight, and temperament, these conditions must be taken into consideration when deciding which sling is suitable for each patients needs. The size/weight designations are merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of a patient. A proper fit will involve the judgement of the caregiver. *it is important to evaluate the width of a patient in relation to the width of the sling. **it is important that no portion of the patient overlap the sides of the sling.