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	06/25/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report the potential theft of money to the State Agency (SA) for 1 of 1 resident (R6) reviewed for personal property. Findings include: R6's face sheet received on 6/25/25, included diagnoses of anxiety and depression. R6's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. No indication of psychosis and no behaviors. R6 was dependent upon staff for most activities of daily living. R6's care plan dated 9/28/23, indicated R6 was at risk for potential abuse, neglect, or exploitation from others. R6 would remain free of documented reports of abuse. Staff would report any physical signs, comments by resident, family members of suspected abuse, neglect or exploitation of resident immediately to their supervisor or other entity as needed. During an interview on 6/23/25 at 7:28 p.m., R6 stated she lost $100 in cash about a month ago. R6 stated, I made the mistake of trusting people. R6 stated she put $100 in various denominations in her billfold. While she was out of her room, someone came in and took it. R6 did not know who took it. R6 stated she received the money from family member (FM)-A who got the cash from the bank from her social security payment. R6 stated she kept the cash in a billfold that she kept in the right side pocket of her recliner. R6 stated she talked to social services director (SSD)-A about it. Review of progress notes from October 2024, to current; facility grievances for the past six months, and facility SA reports, revealed no documentation or reporting of the allegation of potential theft. During an interview on 6/24/25 at 12:48 p.m., registered nurse (RN)-A stated she heard something about R6 missing money about two weeks ago. It had not been reported to her and she did not know anything about it. During an interview on 6/24/25 at 12:49 p.m., nursing assistant (NA)-A stated he did not know anything about R6 missing money. (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/25 at 3:00 p.m. SSD-A stated she was informed of R6's missing money by FM-A on 6/6/25. SSD-A stated she was unaware R6 had a billfold and money in her possession as residents were discouraged from keeping money in their room. SSD-A stated FM-A informed her the cash was in small bills and did not know how the total amount. R6 liked to use the cash to put in greeting cards. SSD-A told FM-A she would investigate and talk to staff. SSD-A stated she was aware of facility policy to report allegations of missing money, but because FM-A told SSD-A she did not want law enforcement notified, nor did she want anything done about the missing money, she did not think it needed to be reported. Attempts to contact and speak to FM-A were unsuccessful. During an interview on 6/25/25 at 8:48 a.m., the assistant administrator (AA)-C, SSD-A and the director of nursing (DON) were informed of findings - failure to report an allegation of potential theft to the SA and to law enforcement. All were aware of the missing money. The DON stated the missing money had been followed up on by SSD-A. AA-C stated he too had talked to R6 and FM-A. FM-A could not recall how much money R6 had; that it had been in small denominations; nor could either R6 or FM-A recall the last time they saw the money. SSD-A again stated she did not think she needed to report because FM-A told her she didn't want anything done about the missing money. Following discussion, SSD-A stated she acknowledged the missing money should have been reported. The Facility Assessment with review date of 4/17/25, indicated every staff member had knowledge competency in abuse, neglect, exploitation, and misappropriation. Training included procedures for reporting incidents of abuse, neglect, exploitation and misuse of resident property. Facility Abuse, Neglect and Exploitation policy dated 4/17/25, indicated alleged violations would be reported to the state agency and all other required agencies (e.g., law enforcement when applicable) within specified timeframes, no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily harm. The administrator would follow up with government agencies to confirm the initial report was received and to report the results of the investigation when final within five working days of the incident, as required by agencies. Facility Reporting Reasonable Suspicion of a Crime policy with review date of 7/2023, indicated examples of situations that would be considered crimes included theft. The facility would do all that was within its control to prevent occurrences of resident abuse, neglect, exploitation, mistreatment and misappropriation of property. That included policies for reporting such incidents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to investigate the potential theft of money for 1 of 1 resident (R6) reviewed for personal property. Findings include: R6's face sheet received on 6/25/25, included diagnoses of anxiety and depression. R6's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. No indication of psychosis and no behaviors. R6 was dependent upon staff for most activities of daily living. R6's care plan dated 9/28/23, indicated R6 was at risk for potential abuse, neglect, or exploitation from others. R6 would remain free of documented reports of abuse. Staff would report any physical signs, comments by resident, family members of suspected abuse, neglect or exploitation of resident immediately to their supervisor or other entity as needed. During an interview on 6/23/25 at 7:28 p.m., R6 stated she lost $100 in cash about a month ago. R6 stated, I made the mistake of trusting people. R6 stated she put $100 in various denominations in her billfold. While she was out of her room, someone came in and took it. R6 did not know who took it. R6 stated she received the money from family member (FM)-A who got the cash from the bank from her social security payment. R6 stated she kept the cash in a billfold that she kept in the right side pocket of her recliner. R6 stated she talked to social services director (SSD)-A about it. During an interview on 6/24/25 at 03:00 p.m., social services director (SSD)-A, who was responsible for investigating and documenting allegations of theft, stated she was aware of the allegation of R6's missing money and had investigated it. When asked to see documentation of the investigation, SSD-A provided the following: Writer was informed at 230 on June 6th that R6 had money missing by family member (FM)-A. She was unsure of the amount only that they were smaller bills. Writer spoke with licensed practical nurse (LPN)-A, nursing assistant (NA)-C, NA-B and LPN-B about the missing money. LPN-A said that she had seen the wallet out on Thursday, and was surprised because she didn't know she had one here. LPN-B also said she saw it on Thursday. The rest had not seen it they told writer. FM-A said I told her not to have money here but she doesn't listen. She uses the cash for putting in cards. FM-A said she did not want the police involved and did not want anything done, as she knew that R6 shouldn't have cash. Writer did remind her of the trust account. She said I know. The notes were typed on a half sheet of paper, not dated, nor authenticated with the name and title of the author. R6's last name wasn't identified, nor was the name of FM-A. Staff were identified by first name only and no titles. SSD-A verified it had been written by her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon continued interview, SSD-A stated she only documented the interview of four nursing staff. A laundry staff interview was not documented, nor was a conversation with the maintenance director who told her he had not seen anything. SSD-A admitted she had not talked to housekeeping staff, activities staff, or other employees who may have been in R6's room and/or who may have seen something. SSD-A admitted she had not interviewed residents to determine if they were missing money or other personal property. SSD-A stated she interviewed R6, but did not document it. SSD-A stated the facility did not have cameras to view activity going on in hallways. SSD-A stated R6's room was searched and no money was found. During an interview on 6/25/25 at 8:48 a.m., the assistant administrator (AA)-C, SSD-A and the director of nursing were informed of findings - failure to investigate an allegation of potential theft. All were aware of the missing money. The DON stated the missing money had been follow-up on by SSD-A. AA-C stated he too had talked to R6 and FM-A. FM-A could not recall how much money R6 had; that it had been in small denominations; nor could either R6 or FM-A recall the last time they saw the money. SSD-A admitted her investigation of the potential theft of R6's money was not thorough, nor was the documentation of her investigation. The Facility Assessment with review date of 4/17/25, indicated every staff member had knowledge competency in abuse, neglect, exploitation, and misappropriation. Training included procedures for reporting incidents of abuse, neglect, exploitation and misuse of resident property. Facility Abuse, Neglect and Exploitation policy dated 4/17/25, indicated an immediate investigation would be warranted when suspicion of abuse, neglect or exploitation, or report of abuse, neglect or exploitation occur. Written procedures for investigation include identifying staff responsible for the investigation, identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who may have knowledge of the allegation. Provide complete and thorough documentation of the investigation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to accurately code antipsychotic medication use on Section N of the Minimum Data Set (MDS) for 1 of 5 residents (R16) reviewed for unnecessary medications. Findings include: R16's quarterly Minimum data set (MDS) assessment dated [DATE], indicated no cognitive impairment, diagnoses included schizophrenia diagnosis of diabetes mellitus, and indicated R16 did not receive antipsychotic medications since admission/entry. R16's care plan dated 4/29/25, indicated R16 received an antipsychotic medication olanzapine (antipsychotic medication used to manage symptoms of mental health conditions) for management of schizophrenia. R16's medication administration record (MAR) dated 4/1/25-4/30/25, indicated olanzapine oral tablet 20 mg (milligrams) give 1 tablet by mouth at bedtime related to schizophrenia. On 6/24/25 at 3:46 p.m., the director of nursing (DON) confirmed that she completed R16's MDS dated [DATE], and confirmed section N was inaccurately coded and should have indicated R16 was receiving an antipsychotic medication. The DON stated accurately coding the MDS was important because it reflected the plan of care for the resident. Facility Conducting an Accurate Resident Assessment policy 3/25, indicated : The represent the policy is to assure that all residents receive an accurate assessment reflective of the resident status at the time of assessment by staff qualified to assess relevant care areas, The appropriate qualified health professional will correctly document the residents medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure plates, trays, and plate covers were completely dry before storing, and failed to ensure refrigerated food was disposed of timely to prevent bacterial growth and foodborne illness. This had the potential to affect all 18 residents residing in the facility. Findings include: During initial kitchen observation on 6/23/25 at 6:25 p.m., dietary aide (DA)-A was washing dishes. Clean plates, serving trays, and plate covers were lined up air drying near the dishwasher. During observation and interview on 6/23/25 at 7:00 p.m., DA-A had put all dishes away. DA-A was asked to lift two plates, two serving trays, and two plate covers from where they were placed stacked on top of each other on shelves without space between them to allow drainage or air drying. All plates, serving trays, and plate covers observed had visible water droplets on them. DA-A stated she always put dishes away prior to leaving her shift and thought they were dry when she put them away. During further initial kitchen observation on 6/23/25 at 6:25 p.m., DA-A opened an upright Traulson brand two-door refrigerator. A sign on the left door of the refrigerator indicated food needed to be dated when opened and either eaten, frozen, or disposed of by day seven of refrigeration. The refrigerator contained hot fudge dated 6/14/25, and cheese sauce dated 6/9/25. During interview on 6/23/25 at 6:25 p.m., DA-A stated she did not know who was supposed to dispose of food from the refrigerator. DA-A confirmed the hot fudge and cheese sauce was outdated according to the sign on the refrigerator door. During interview on 6/24/25 at 11:50 a.m., dietary director (DD) stated she expected staff to allow dishes to fully air dry prior to putting them away or to stack them staggered so water could drain off and air could flow through. DD stated open food in the refrigerator should have been removed in 7 days if not used for leftovers and she usually checked the refrigerator but had not had time since the weekend. DD stated letting dishes air dry too prevent bacterial growth and removing outdated food was to prevent foodborne illness. During interview on 6/24/25 at 2:00 p.m., registered nurse (RN)-B also known as the infection preventionist, stated not allowing dishes to air dry could lead to bacterial growth. During interview on 6/24/25 at 2:18 p.m., assistant administrator (AA) stated dishes should not be put away wet and should be allowed to fully dry. During interview on 6/24/25 at 9:37 a.m., administrator (A) stated she expected dietary staff to follow direction of DD for drying dishes and food disposal. Facility Dish Machine Policy and Procedure- Use of Dishwasher dated 7/31/24, stated the following: 4. Once dishes have run through cycles in the dish machine, dishes will be placed on the clean side of the dishwasher to air dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Date Marking for Food Safety dated 3/25/20, stated the following: 1. Refrigerated, ready-to-eat, time/temperature control for safety food shall be held at temperature of 41 degrees or less for a maximum of seven days. 5. The discard day or date may not exceed the manufacturer's use-by date, or seven days, whichever is earliest. The date of opening or preparation counts as day one. 6. The head cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and document review, the facility failed to ensure a fan blowing directly on clean dishes was free of dust and debris. This had the potential to affect all 18 residents residing in the facility. Findings include: During initial kitchen observation on 6/23/25 at 6:25 p.m., dietary aide (DA)-A was washing dishes. Clean plates, serving trays, and plate covers were lined up air drying near the dishwasher. A small oscillating fan was turned on and blowing directly on the clean, wet dishes. The fan had visible dust and debris on the blades and surrounding cage. During observation and interview on 6/23/25 at 7:00 p.m., DA-A had put all dishes away. DA-A stated the fan was very dirty and probably should not have been blowing on the clean dishes. DA-A stated she was unaware of who was responsible for cleaning the fan or when the fan had last been cleaned. During interview on 6/24/25 at 11:50 a.m., dietary director (DD) stated was not aware the fan had gotten that dirty and thought it had just been cleaned last week. DD stated when the air conditioner ran it caused more build-up on the fan. DD stated she did not want the fan there and it had been removed. DD stated letting dishes air dry and not allowing the dirty fan to blow on clean dishes was to prevent bacterial growth. During interview on 6/24/25 at 2:00 p.m., registered nurse (RN)-B also known as the infection preventionist, stated she was not aware a fan was blowing on the clean dishes and did not think that was allowed. RN-B stated she did not know if there was a cleaning schedule for the fan and she would prefer if the fan was removed to prevent spread of infection in the kitchen. During interview on 6/24/25 at 2:18 p.m., assistant administrator (AA) stated he was not aware there was a dirty fan blowing on clean dishes but had been made aware of it and thought the fan should be removed from the clean dish area. During interview on 6/24/25 at 9:37 a.m., administrator (A) stated she expected dietary staff to follow direction of DD for drying dishes and fans. Facility Dish Machine Policy and Procedure- Use of Dishwasher dated 7/31/24, stated the following: 4. Once dishes have run through cycles in the dish machine, dishes will be placed on the clean side of the dishwasher to air dry. No air circulation assistive devices (i.e. fans) will be used in the dish drying area.