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	06/04/2026

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide physical therapy and occupational therapy as ordered for 5 of 5 residents (R2, R8, R13, R25, R26) reviewed for rehabilitation and restorative services. Findings include: R2's face sheet printed 6/4/26, indicated diagnoses of acute heart failure, chronic pain syndrome, and kidney disease. R2's care plan dated 2/17/26, indicated acute and chronic pain related to lower leg ulcers and chronic pain syndrome with interventions of non-medicated pain relief measures such as massage, physical therapy, and strengthening and stretching exercises. R2's physician's orders dated 5/29/26, indicated occupational and physical therapy eval and treat. R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, rejection of care one to three days, use of wheelchair, dependent on staff for toileting hygiene, lower body dressing, and personal hygiene. R8's face sheet printed 6/4/26, indicated diagnoses of dysphagia (difficulty swallowing), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right side impairments due to stroke). R8's care plan dated 4/14/26, indicated activities of daily living (ADL) assistance needed for transfers due to recent stroke, with intervention on one assist for transfers and occupational and physical therapy to eval and treat. R8's physician's orders dated 4/14/26, indicated occupational, physical, and speech therapy eval and treat. R8's admission MDS assessment dated [DATE], indicated moderately impaired cognition, no behaviors, use of wheelchair, dependent on staff for bathing, toileting hygiene, and dressing. R13's face sheet printed 6/4/26, indicated diagnoses of end stage kidney disease, heart failure, and diabetes mellitus. R13's care plan dated 9/26/25, indicated desire to go home after meeting goals in therapy with interventions of evaluating and discussing the prognosis for independent or assisted living. (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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