STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Home	102 County State Aid Highway 9 Belview, MN 56214

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. 34083 Based on interview and document review the facility failed to follow facility policies and ensure reports to the State Agency (SA) were submitted not later than 2 hours for an incident of potential abuse or neglect for 1 of 1 resident (R15) after the facility became aware of the incident. Findings include: Review of 2/14/25 at 11:03 a.m. Incident Huddle progress note identified R15 had an unwitnessed fall from his Broda chair (wheelchair that provides comfort, support, and mobility) on 2/13/25 at 4:00 p.m., when he was unattended in the day room. R15 was not able to verbalize what he had been attempting to do related to his dementia. The note identified no injury from this fall, but identified his right hand remained swollen from a previous middle finger fracture. R15's 3/19/25 quarterly Minimum Data Set (MDS) assessment identified he had severe cognitive impairment, and moderate to severe depression according to his PHQ-9 score of 15/27. R15 required extensive to total assistance with activities of daily living (ADLS) from 1-2 staff persons. R15's diagnoses included non-traumatic brain dysfunction, dementia, depression, and other fracture. He received pain medications as needed, and scheduled antidepressant and anti-platelet medications. R15's current undated care plan identified he required total assistance with ADLs and had the potential for physical aggression toward staff during cares related to his dementia. Triggers were identified as not liking to be woken up, with de-escalation techniques of allowing time to wake up, explain tasks prior to initiating, move slowly, and leave in a safe position and return later. The care plan identified he had a fall without injury and a history of frequent falls. He had a fall alert system on both his bed and wheelchair, a floor mat with the bed in low position, and following the 2/13/25 fall the intervention to tip the Broda chair back slightly when left unattended in his chair. Nursing staff were to be notified if he was left in his Broda chair unattended, and out of his room. Interview on 4/22/25 at 1:26 p.m., with nursing assistant (NA)-A reported R15 had dementia and was not able to consistently communicate his needs. She reported he required 1-2 staff assistance with ADLS and that he also was combative at times when staff were attempting to provide cares. She reported she was not aware of R15 having any recent falls, and she was not aware of how he had injured his right hand. NA-A reported she had received annual education on Vulnerable adult and reporting of bruising or injury to the charge nurse. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/22/25 at 1:45 p.m., with the DON reported R15 had fallen from his Broda chair on 2/13/25 p. m. at 4:00 p.m. when he had been positioned upright in his Broda chair and left unattended in the day room. There was no injury noted on the incident report of the unwitnessed fall, but the progress note identified swelling in his right hand from a previous finger fracture. The DON reported it was felt R15 had injured the middle finger on his right hand when he had struck out at staff, but she was not able to provide any report of the unwitnessed injury, or that a report had been made to the SA. She reported she would need to investigate the matter further, for documentation of the incident. A subsequent interview on 4/22/25 at 1:50 p.m. with the DON identified she had reviewed R15's EMR, and the Risk Management record, and there was no documentation of an injury prior to the 1/23/25 note, nor was she able to locate an incident report or evidence the incident on 1/23/25 had been reported to the SA. She stated her expectation for any resident bruise or injury to be reported and documented, and if there was no evidence of the cause it should have been reported to the SA. Interview on 4/22/25 at 3:50 p.m. with the facility administrator reported his expectation for an injury of unknown origin to be investigated, and incident report completed and reported to the SA according to the facility policy and regulations. Interview on 4/22/25 at 3:53 p.m., with the consulting administrator reported she recalled having been notified of R15's injury and had contacted the interim Social Services Designee (SSD) to investigate the incident. She reported she thought the injury had occurred due to R15 being combative, and she would look for the investigation report. She questioned if the injury was reportable to the SA, but agreed the injury was unwitnessed and there was no documentation in the record of a cause of injury. On 4/22/25 at 4:25 p.m., the administrative consultant returned and identified there was not adequate investigation or reporting of the injury of unknown cause which she would have expected to be documented on an incident report and reported the SA according to the facility policy on Abuse. Review of the undated posting Suspected Abuse/Reportable Incidents Guide identified suspected abuse and/or reportable incidents were reportable to the SA within 2 hours of discovery. The instructions directed staff to report and then investigate. Staff were to locate the Vulnerable Adult Reporting packet which provided step by step instructions on the process to be followed. Examples of reportable incidents to the SA included injuries of unknown origin, such as a fracture with no fall, bruises, or injury without a known cause. Review of the February 2024 Policy Abuse Prevention Program identified the facility was to develop and ensure implementation of policies to train staff in abuse prevention and identify and report incidents in addition to handling verbal or physical aggressive resident behavior. Review of the undated facility policy Conducting Internal Investigations identified investigations could include review and preservation of any documents, interview of appropriate staff and/or residents; review of policies and procedures; collaboration with facility administration' and engagement of an outside consultant, authority, or law enforcement to assist in the investigation.

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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. 34083 Based on interview and document review the facility failed to throughly investigate an injury of unknown origin for 1 of 1 resident (R15). Findings include: Review of 2/14/25 at 11:03 a.m. Incident Huddle progress note identified R15 had an unwitnessed fall from his Broda chair (wheelchair that provides comfort, support, and mobility) on 2/13/25 at 4:00 p.m., when he was unattended in the day room. R15 was not able to verbalize what he had been attempting to do related to his dementia. The note identified no injury from this fall, but identified his right hand remained swollen from a previous middle finger fracture. R15's 3/19/25 quarterly Minimum Data Set (MDS) assessment identified he had severe cognitive impairment, and moderate to severe depression according to his PHQ-9 score of 15/27. R15 required extensive to total assistance with activities of daily living (ADLS) from 1-2 staff persons. R15's diagnoses included non-traumatic brain dysfunction, dementia, depression, and other fracture. He received pain medications as needed, and scheduled antidepressant and antiplatelet medications. R15's current undated care plan identified he required total assistance with ADLs and had the potential for physical aggression toward staff during cares related to his dementia. Triggers were identified as not liking to be woken up, with de-escalation techniques of allowing time to wake up, explain tasks prior to initiating, move slowly, and leave in a safe position and return later. The care plan identified he had a fall without injury and a history of frequent falls. He had a fall alert system on both his bed and wheelchair, a floor mat with the bed in low position, and following the 2/13/25 fall the intervention to tip the Broda chair back slightly when left unattended in his chair. Nursing staff were to be notified if he was left in his Broda chair unattended, and out of his room. Review of Risk Management in Point Click Care (PCC) for R15 failed to identify the injury on his right middle finger that was documented on 1/23/25 at 3:38 p.m. in the Progress notes by an unidentified Restorative NA. The progress note on 1/24/25 at 2:53 p.m., identified swelling in R15's right hand, and no evidence of injury. On 1/24/25 at 7:17 p.m., the progress note identified greenish/purplish discoloration between R15's second, third and fourth fingers and he became, teary eyed when his hand was touched. The note identified R15 was administered Tylenol for discomfort, and a family member was contacted and gave authorization for R15 to be further evaluated in the Emergency Department. R15 returned on 1/24/25 at 9:30 p.m. with a diagnosis of a closed, displaced fracture of his proximal phalanx of his right middle finger. Both the family member and the DON were notified of R15's return and diagnosis. There was no documentation of investigation into R15's right hand fracture. Interview on 4/22/25 at 1:26 p.m., with nursing assistant (NA)-A reported R15 had dementia and was not able to consistently communicate his needs. She reported he required 1-2 staff assistance with ADLS and that he also was combative at times when staff were attempting to provide cares. She reported she was not aware of R15 having any recent falls, and she was not aware of how he had injured his right hand. NA-A reported she had received annual education on Vulnerable adult and reporting of bruising or injury to the charge nurse. (continued on next page)

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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	Interview on 4/22/25 at 1:45 p.m., with the DON reported R15 had fallen from his Broda chair on 2/13/25 p. m. at 4:00 p.m. when he had been positioned upright in his Broda chair and left unattended in the day room. An incident report was available in PCC and identified he had no injury from the unwitnessed fall, but the progress note Incident/Huddle on 2/14/25 at 11:03 a.m. identified swelling in his right hand from a previous finger fracture. The DON reported it was felt R15 had injured the middle finger on his right hand when he had struck out at staff, but she was not able to provide any documentation to indicate the finger fracture had been investigated, nor that a report had been made to the SA. A subsequent interview on 4/22/25 at 1:50 p.m. with the DON identified she had reviewed R15's EMR, and the Risk Management record, and confirmed there was no documentation of an injury prior to the 1/23/25 note, nor was she able to locate an incident report or evidence the incident on 1/23/25 had been reported to the SA. She stated her expectation for any resident bruise or injury to be reported and documented, and if there was no evidence of the cause it should have been reported to the SA. Interview on 4/22/25 at 3:50 p.m. with the facility administrator reported his expectation for an injury of unknown origin to be investigated, and incident report completed and reported to the SA according to the facility policy and regulations. Interview on 4/22/25 at 3:53 p.m., with the consulting administrator reported she recalled having been notified of R15's injury and had contacted the interim Social Services Designee (SSD) to investigate the incident. She reported she thought the injury had occurred due to R15 being combative, but returned at 4:25 p.m. and confirmed R15's finger fracture had not been investigated appropriately and an incident report should have been completed according to her expectation. She also voiced agreement that there should have been a report to the SA and further investigation following R15's ED evaluation with diagnosis of a fracture to his right middle finger and she would look for the investigation report. She questioned if the injury was reportable to the SA, but agreed the injury was unwitnessed and there was no documentation in the record of a cause of injury. Review of the undated, facility policy Conducting Internal Investigations identified investigations could include review and preservation of any documents, interview of appropriate staff and/or residents; review of policies and procedures; collaboration with facility administration' and engagement of an outside consultant, authority, or law enforcement to assist in the investigation.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 39988 Based on interview and document review, the facility failed to ensure data submitted to the Quality Assurance and Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 18 residents. Findings include: Review of the monthly QAPI meeting minutes from November 2024 identified department heads were bringing data forth to QAPI on various topics such as medication errors, falls, pressure ulcers, weight loss, pharmacy services, infection control, admissions and discharges, staff agency use, adverse event monitoring however, only falls and pressure ulcers had a benchmark goal identified with data but no analysis of the data or identified actions the facility was going to take to achieve their goals and monitoring to determine if goals were met or QAPI needed to continue monitoring to ensure compliance. The other areas identified had no documented benchmarks for goals the facility was trying to achieve, nor analysis of the data brought forth, or identified actions the facility was going to take to achieve a goal. Review of the monthly QAPI meeting minutes from January 2025 identified department heads were bringing data forth to QAPI on various topics such as medications, nutritional risk, staffing, admissions and discharges, activities, infection control, falls and adverse event monitoring. There were no documented benchmarks for goals the facility was trying to achieve, nor analysis of data brought forth, identified actions the facility was going to take to achieve their goals, and monitoring to determine if goals were met or QAPI needed to continue monitoring to ensure compliance. Review of the monthly QAPI meeting minutes from April 2025 identified department heads were bringing data forth to QAPI on various topics such as falls, quality indicator data, activities, pharmacy report, weight summary report, maintenance report, admissions and discharges however, there was no documented benchmarks for goals the facility was trying to achieve, nor analysis of data brought forth, identified actions the facility was going to take to achieve their goals, and monitoring to determine if goals were met or QAPI needed to continue monitoring to ensure compliance. Interview on 4/22/25 at 3:53 p.m., with regional administrator identified the facility had not identified goals, action plans, or analyzed data brought forth in the QAPI meetings and the facility would be working on that. Review of the undated, Quality Assurance and Performance Improvement (QAPI) policy identified the QAPI committee would oversee areas for improvement, develop an action plan, and analyze the results of the plan. The facility would maintain evidence of the ongoing QAPI program with documentation of data, analysis, and implementation and evaluation of actions for improvement activities.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39988 Based on interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas identified thorough and appropriate data collection and analysis and evaluation of the identified concern(s) during QAPI. This had the potential to affect all 18 residents. Findings include: Review of QAPI minutes from 11/8/24 through 4/11/25 identified No PIP projects were noted. Interview on 4/22/25 with regional administrator (RA) identified the facility had identified a PIP project however, they had not developed a goal, there was no action plan, it had not been discussed at the QAPI meeting, and no staff had been trained. The RA agreed the facility failed to have the identified PIP follow through. Review of the undated, Quality Assurance and Performance Improvement (QAPI) policy identified the QAPI committee would oversee areas for improvement, develop an action plan, and analyze the results of the plan. The facility would maintain evidence of the ongoing QAPI program with documentation of data, analysis, and implementation and evaluation of actions for improvement activities.The policy identified that the facility would conduct at least one distinct PIP project annually that focused on high risk or problem areas.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 39988 Based on interview, and document review, the Quality Assurance (QA) committee failed to ensure they received reports from the infection preventionist on the infection control program for 1 of 3 quarters reviewed. Findings include: Review of monthly QAPI meeting minutes of November 2024, January 2025 and April 2025 identified that April had no data brought forth or report on the infection control program for review by the QAPI committee. The April QAPI meeting sign in sheet identified attendance by the director of nursing (DON) as the infection preventions/DON. Interview on 4/22/25 at 4:46 p.m., with the administrator identified he was unaware that the infection preventionist had not provided data or a report on the infection control program however, he confirmed he was at the meeting. He revealed he had received his administrator license 4 weeks ago and the facility had a lot of turnovers recently as the social service designee had resigned and the director of nursing was an interim, so he did not realize the infection control information had been missed. No policy obtained related infection preventionist presenting at QAPI meeting related to infection trends or other pertinent data.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49336 Based on interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employees would be able to return to work after an illness dependent upon their symptoms. In addition, the facility failed to ensure 2 of 5 (certified nursing assistant and dietary aide) had completed tuberculosis testing (TST) upon hire. This had the potential to affect all 18 residents in the facility Findings include: EMPLOYEE SURVEILLANCE Review of Employee Absence Report sheets from April 2025 identified the following areas of documentation: employee name, date, time, called in, scheduled shift, reason for absence, illness and symptoms, physician visit and date of visit. However, the facility did not accurately complete the logs to ensure all necessary information was monitored. On: 1) 4/2/25, nurse aide (NA)-D was noted to have called in sick from work with symptoms of not feeling well and unable to sleep and stomach issues. U-A was not seen by a physician. There was no mention when or if NA-D's symptoms resolved prior to returning to work. 2) 4/2/25, the activity director (AD) was noted absent from work. It is unknown if they reported to work that day, developed symptoms and then left, or had called in. Symptoms noted were a cough, stuffy nose, sore throat, and a tight chest. There was no mention if they had tested for potential COVID or if/when symptoms resolved, and if they were cleared to return to work. 3) 4/07/25, the AD was then was identified as having had pneumonia. The form indicated the AD had seen the physician. There was no mention of what symptoms the AD had, if they had tested for potential COVID, if the pneumonia was potentially contagious, or if/when the AD's symptoms resolved. 4) 4/17/25, NA-C called in for work. No symptoms were noted. The form lacked any other details. 5) 4/17/25, the administrator was noted to be absent. It is unknown if the administrator called in to work or became ill after reporting to work. Symptoms reported were cough and loss of voice. The form identified the administrator had tested for COVID and influenza and was found to be negative. 6) 4/18/25, licensed practical nurse (LPN)-A was sick and reported to have had a fever. There was no mention if staff had tested for potential COVID, or if/when LPN-A's symptoms resolved. There was no mention on the forms of dates when staff returned to work or if they met any criteria to return to work. Interview on 4/22/25 at 10:48 a.m., the interim director of nursing (DON) identified the facility had not completed employee illness surveillance. The DON identified there were areas of concern that was deficient and would need to implement a process to manage effective tracking of employee illnesses. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Employee Illness policy identified the facility staff who were direct or indirect care staff, who had symptoms of an illness, would report the to charge nurse or the infection preventionist (IP) to determine when an employee was to return to work. The policy identified examples of illnesses, work restrictions, and duration of the restriction for facility staff and was directed contact the state department for guidance. Lastly, the policy indicated facility staff was to contact the IP or supervisor before returning to work. TB Review of the July 2013, Tuberculosis Control in Minnesota Health Care Settings identified all employees should have TB screening and an employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 12 months before hire. The second TST may be performed after the health care worker (HCW) starts working with patients. Review of employee health file for certified nursing assistant (NA)-B identified NA-B was hired on 2/11/25. NA-B had a baseline TB symptom screening and a first step TST completed on 3/19/25. The form lacked evidence of a second TST. Review of employee health file of dietary aide (DA)-A was hired 3/11/25. DA-A had a baseline TB symptom screening and a first step TST on 3/11/25. The form lacked evidence of a second TST. Interview on 4/22/25 at 10:56 a.m. with registered nurse (RN)-B consultant and the interim director of nursing (DON) had voiced agreement that new hires should have TB screening and testing completed upon hire. Review of current, undated Tuberculosis (TB) Screening--Employees policy identified the facility should screen all health care personnel upon hire and was to follow the centers of disease control and prevention (CDC) recommendations. In addition, the TB screening was to include a baseline individual TB risk assessment, TB symptom evaluation, and TB testing.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 49336 Based on interview and document review the facility failed to ensure the acting infection preventionist (IP) (who is the facility's director of nursing (DON)) had completed specialized training in infection prevention and control. This had the potential to affect all 18 residents residing in the facility. Findings include: Interview on 4/22/25 at 10:23 a.m., with the interim director of nursing (DON) identified she oversees the infection control program but had not completed her IP training and certification course. Interview on 4/22/25 at 10:24 a.m., with registered nurse (RN)-B, who is the facility consultant, identified the facility used advertisements through online job boards to recruit a permanent DON, as well, as an assistant director of nursing (ADON) to oversee the infection control program. Interview on 4/22/25 at 10:46 a.m., with the regional administrator identified the facility did not have a certified IP who worked at least part time nor onsite at the facility. An Indeed (online job search website) post identified the facility had listed for an IP under the ADON position. The qualification was for the ADON to have education, training, experience or certification related to infection control and prevention. Review of 4/22/25 at 5:25 p.m., email correspondence identified the interim DON was hired January 2025. Review of the current, undated facility's Infection Surveillance-Overview policy identified the IP would lead, document and monitor surveillance findings to the quality assessment and assurance committee (QAA), and local health authorities, as needed. The IP was to properly identify active communicable disease or infections, provide staff training, data collection of infected residents, observation and audits, and to track employees, volunteer and agency staff of flu and gastrointestinal outbreaks, as needed.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 39988 Based on interview and document review, the facility failed to provide mandatory training on 1 of 1 facility's specific Quality Assurance Performance Improvement (QAPI) Program to all staff to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how staff was to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. This had the potential to affect all 18 residents. Findings include: Interview on 4/22/25 at 11:03 a.m., with nursing assistant (NA)-C identified that the facility had QAPI meetings, but she was unsure when they last had one. She was unaware of anything the facility was working on and had no training on what the facility was working on for QAPI but did complete QAPI training on Health Academy the facilities online training. Interview on 4/22/25 at 3:53 p.m., with regional administrator identified that there had been no staff training specific to the facility's own QAPI program. Interview on 4/22/25 at 4:28 p.m. with dietary aide (DA)-B identified she completed QAPI training on the Health Academy but had no other training. She reported she would not know anything about what the facility was working on as she worked in the kitchen. Interview on 4/22/25 at 4:30 p.m., with activity aide (AA)-A identified she had no training on QAPI and was not aware of anything the facility had worked on or was working on. No policy related to facility staff training on their QAPI program provided by end of survey.