STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor Nursing Home	308 Sherman Avenue Ellsworth, MN 56129

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47497 Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (R5) had been appropriately assessed for wheelchair size by therapy. Findings include: R5's 1/3/25, annual Minimum Data Set (MDS) assessment identified she had admitted to the facility in January of 2022, with intact cognition. She had no psychosocial behaviors, and required extensive assistance from staff to complete Activities of Daily Living (ADL). R5 had diagnoses of severe morbid obesity, arthritis, and reduced mobility. She had pain that occasionally interfered with her ADL and had a stage II pressure ulcer (characterized by partial-thickness skin loss). R5 was not receiving any therapy. Observation and interview on 3/24/25 at 2:57 p.m., of R5 in her room, identified she was seated in a recliner with her legs elevated. R5 identified she has asked for a new wheelchair. She reported she does not go to any activities or leave her room for anything. She would like to take part in activities but I'm stuck in here because it was so painful to sit in her wheelchair. Interview on 3/26/25 at 2:24 p.m., with the activity aid (AA)-A identified R5 used to come out for activities but then started refusing, she said its painful to sit in her wheelchair so she cant come to activities. AA-A identified she had reported the concern to the director of nursing but did not know if anything had been done. Interview on 3/26/25 at 2:28 p.m., with the nursing assistant (NA)-A identified she was aware R5 does not come out of her room because her wheelchair is uncomfortable. NA-A identified she had reported the refusals and the reason given to the director of nursing. Interview on 3/26/25 at 3:52 p.m., with the registered nurse (RN)-A identified she knew R5 refused to come out of her room but was not aware of the reason. She reports she thought that was her normal, she could not recall anyone telling her that it was because of her wheelchair being uncomfortable. R5's current, undated care plan identified R5: (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Was at risk for feelings of powerlessness related to (r/t) her inability to regain strength and independence to return to her home as she had hoped on admission and was unable to take care of herself independently. R5 was noted to have preferred to stay in her room; resident expresses that she is fearful of falling; at times resident states/seems fearful of motion/movement in lift and in wheelchair. One of R5's goals was she would spend time out of her room as she feels up to it. 2) Was noted to be at risk for impaired individual coping r/t NH placement, impaired mobility, and at times would appear fearful of motion/movement with EZ-stand and when she was in her wheelchair as resident will scream, yell, and/or cry when staff is assisting her in EZ-stand and in her wheelchair, with an intervention to discuss resident fears with resident and inform the charge nurse when R5 was upset, screaming, yelling and/or crying. 3) Has little or no activity involvement r/t disinterest and immobility and physical limitations. Staff were to establish and record R5's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary and required assistance/escort to activity functions. 4) has ADL self-care performance deficit r/t activity intolerance, morbid obesity, impaired mobility. 5) Chronic Pain r/t osteoarthritis, impaired mobility, and morbid obesity with a goal to not have an interruption in normal activities due to pain. Staff were to monitor/document for probable cause of each pain episode and remove/limit causes where possible and monitor resident's existing conditions which may increase pain and or discomfort. 6) has impairment to skin integrity r/t chronic peripheral edema (swelling of limbs),decreased mobility, obesity and refusals to be repositioned every 2 hours. Staff were to identify/document potential causative factors and eliminate/resolve where possible. R5 required a pressure relieving cushion to protect the skin while up in her chair. Review of R5's progress notes and medical record identified there was no mention if R5 had been assessed per the care plan above as to why she refused to be repositioned, or why she declined to be seated in her wheelchair. There was also no indication therapy had been notified to assess R5 for appropriate wheelchair size. Interview on 3/26/25, at 3:56 p.m., with the licensed practical nurse (LPN)-A reported R5 has the right to refuse. She identified she had never asked her why she refused to come out of her room, but she recalled her being uncomfortable sitting on the commode and states she is almost always uncomfortable. Interview on 3/27/25 at 1:54 p.m., with the administrator identified he agreed the facility had not reached out to R5's physician to request an assessment by therapy for an appropriate wheelchair and had no documentation identifying that they had attempted any interventions to improve R5's comfort while sitting in her wheelchair. The administrator identified he would have expected nursing to update R5's physician and request an order for her to be evaluated by therapy. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Therapy was unavailable for interview. Review of the facilities undated Accommodation of Needs policy identified the facility would assist the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. Staff attitudes and behaviors must be directed towards assisting the resident in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 47497 Based on observation, interview, and document review the facility failed to ensure the hospice plan of care had been integrated with the facility care plan for 2 of 2 residents (R14 and R131) to delineate services provided between the facility and hospice. Findings include: R14's 2/7/25, significant change Minimum Data Set (MDS) assessment identified her cognition was severely impaired and she was dependent on staff to complete all activities of daily living (ADL)'s. R14 had diagnosis of heart failure, arthritis, Alzheimer's disease, chronic pain, and lymphedema. She had vocal indicators of pain, received scheduled pain medication, and had a life expectancy of less than 6 months. Review of R14's current care plan identified she would receive visits from hospice. The care plan lacked any indication when the visits would occur and did not identify what services the facility was to provide nor services the hospice agency was to provide. R131's 3/12/25, admission Minimum Data Set (MDS) identified he had a diagnosis of cancer and was admitted to the facility on hospice with a life expectancy of less than 6 months. Review of R131's care plan identified he was receiving hospice services and had a focus of comfort. The care plan lacked any delineation of what care the hospice agency was to provide verses what care the facility was to provide. Interview on 3/24/25 at 3:15 p.m., with the hospice registered nurse, identified they typically fax the hospice care plan to the facility within 48 hours. She identified they had some communication concerns with the facility staff recently and had to explain to the aids that the bath hospice provides must be in addition to the bathing provided by the facility staff. She also reported the facility aids are responsible for assisting the hospice aid with positioning and dressing when they are at the facility providing a bath, however, at times there are no staff available to assist. Review of the 2016 Comprehensive Person Centered Care Plan policy identified the facility would describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, Incorporate identified problem areas, incorporate risk factors associated with identified problems, reflect the resident's expressed wishes regarding care and treatment goals, and identify the professional services that are responsible for each element of care. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34083 Based on observation and interview the facility failed to avoid the potential risk of burns from 1 of 1 unattended Bunn brand coffee warmer used in the dining room. Findings include: Observation on 3/26/25 at 11:30 a.m., as an unknown dietary staff member entered the dining room and switched on the heating elements on a Bunn double element coffee warmer. The warmer was used to place glass coffee pots on during meals to keep the coffee hot. The coffee warmer with glass pots was positioned on a counter within easy reach of a resident walking or in a wheelchair. The warmer was observed to be very hot when a hand was held an inch above the surface, in addition to the glass coffee pots which held hot coffee. Neither dietary or nursing staff were consistently in the dining room, and no one was observed monitoring the coffee to ensure a resident did not attempt to serve themselves. Interview on 3/26/25 at 11:33 a.m. with the certified dietary manager (CDM), reported the Bunn coffee warmer was turned on prior to meals to allow it to become hot before the glass coffee pots were placed on it for service during the meal. She acknowledged the potential for burns if a resident attempted to self-serve coffee or touched the hot plate surface. The CDM reported she would make a change to utilize a pump type coffee server to eliminate the risk of a resident being burned. Interview on 3/26/25 at 11:55 a.m., with the administrator acknowledged the potential hazard the coffee warmer and glass coffee pots presented. He reported this was the system that had been utilized, but he had not identified the potential hazard. The administrator reported the facility would need to utilize a different method for serving coffee in the dining room and acknowledged the CDM had replaced the warmer and glass pots with a pump type pot for safety following the observation. A policy for safety in the dining room was requested, but not provided prior to survey exit.

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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. 34083 Based on observation and interview, the facility failed to ensure 1 of 1 exhaust vent located above the gas stove was free from accumulation of dirt and grease that had the potential to contaminate food being prepared and served. This had the potential to affect all 28 residents who received food prepared in the facility kitchen. Findings include: Observation and interview on 3/24/25 at 10:45 a.m., during the initial kitchen tour with the certified dietary manager (CDM). identified a large rectangular vent positioned in the wall above the stove. The vent was covered with a black, thick grease-like substance. The CDM reported the vent had been cleaned by maintenance a couple of months previously and she thought the black substance was likely rust and dust. She also reported she had not noticed how it appeared, but stated it needed to be cleaned. Interview on 3/24/25 at 11:30 a.m., with the Maintenance Supervisor (MS) reported he had replaced the vent a couple of months ago due to rust and paint chipping, but he did not realize how much more dirt and grease had accumulated. He reported he was not able to wipe off the black buildup but had to utilize a heavy degreaser to remove it and would need to put it on his maintenance schedule for regular cleaning. A policy on cleaning of vents and equipment in the kitchen was requested but not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34083 Based on observation, interview, and document review the facility failed to ensure the use of appropriate personal protection equipment (PPE) was utilized during blood glucose testing, and subsequent insulin administration for 2 of 2 residents (R7 and R22). In addition, the facility failed to ensure mechanical lifts were regularly cleaned and/or disinfected between resident use. Findings include: Observation on 3/25/25 at 11:30 a.m., as licensed practical nurse (LPN)-A prepared to check R7's BS and administer his lunch time insulin. She retrieved the necessary supplies from the medication cart, retrieved a BS strip from the bottle and placed it into the meter, then went to the dining room and informed R7 she needed to check his BS and administer his insulin. R7 voiced agreement and was transported from the dining room to the tub room for privacy. LPN-A asked which finger he would like to use to test. R7 then held up a finger. With her un-gloved hands, she proceeded to use an alcohol wipe to wipe his finger, then dried it with a cotton ball, picked up the automatic lancet, and lanced R7's finger to obtain a drop of blood. LPN-A then took the meter with the strip in place and touched the drop of blood to the strip, then placed the cotton ball on R7's finger. Still using her un-gloved hands, LPN-A picked up the used lancet, cotton ball, and monitor strip and placed them into the left side pocket of her scrub top. LPN-A continued with her un-gloved hands and picked up the insulin pen, applied the needle, dialed the pen to 2 units, primed the pen, then dialed to the ordered 10 units of insulin and administered the dose in R7's left lower quadrant. LPN-A recapped the pen and placed it into the same scrub top pocket with the used blood glucose items. LPN-A transported R7 back to the dining room, and then returned to the medication cart, applied hand sanitizer, and removed the items from her pocket and disposed of the used lancet, cotton ball, and glucose strip into the sharp's container. She placed the meter on the top of the cart, with un-gloved hands, took the insulin pen from her pocket, removed the needle from the pen and disposed in the sharps container. She then obtained a purple labeled Sani wipe, applied gloves and wiped the surface of the meter for disinfection, wrapped the wipe around the meter and identified it would remain on the meter until dry. LPN-A did sanitize her hands after the conclusion of the deficient practice. Observation on 3/25/25 at 11:39 a.m. with LPN-A identified she reported she also needed to administer insulin to R22. LPN-A transported R22 from the dining room to the tub room for privacy, prepared his insulin pen by wiping the tip with alcohol, attaching the needle, priming with 2 units, then dialing the pen to a total of 14 units. R22 requested the insulin be administered into his right upper arm. With her un-gloved hands, she administered the insulin. LPN-A recapped the insulin pen placed it into her scrub top pocket, transported R22 back to the dining room, and returned to the medication cart. She then she removed the used needle from the insulin pen, disposed in the sharps container and returned the insulin pen to the medication cart drawer. She then cleansed her hands with hand sanitizer. Interview on 3/25/25 at 11:43 a.m., with LPN-A reported she should have been wearing gloves and performed hand hygiene, but stated was nervous at being observed and had forgotten. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/25/25 at 11:55 a.m., with the director of nursing (DON) identified her expectation for all staff to follow infection control measures including appropriate use of PPE when administering medications, and especially when the administration involved contact with blood. She agreed putting contaminated supplies and pens in her scrub pockets and placing contaminated insulin pens back into the medication carts would contaminate any item the pens came into contact with. Review of the 2001 MED-PASS, Inc (revised April 2019) Administering Medications policy identified staff were to follow infections control policies and procedures (handwashing, antiseptic technique, gloves, and any precautions identified) for all medications being administered. 47638 LIFTS Observation on 3/25/25 at 9:04 a.m., CNA in training (CNAT) identified CNAT pushed a Hoyer (total mechanical lift) into a resident room. The door was open as CNAT conversed with the resident and placed the residents designated sling beneath him while he waited for another staff member to assist with the transfer. When another staff member arrived, the door was closed to provide privacy during the transfer from wheelchair to recliner. After the transfer was completed, the residents door was opened and CNAT was observed pushing the hoyer lift out of residents room and down the hall, and into another residents room. The door was again closed while assisting the resident. Interview on 3/25/25 at 9:15 a.m., CNAT confirmed the lift was not cleaned between residents. He stated he was trained to complete cleaning of lifts at the end of each shift, and believed this was their policy. CNAT confirmed neither resident was on EBP. Interview on 3/25/25 at 3:59 p.m., with the director of nursing (DON) who was also the Infection Preventionist, identified lifts were to be cleaned and disinfected between residents regardless of their precaution status. DON stated new staff were trained to clean and disinfect them after each resident use. DON also stated CNAT had received a lot of information all at once, and she had clarified this expectation earlier when CNAT asked her about it. Review of the 2001 MED-PASS, Inc (revised October 2018) Cleaning and Disinfection of Resident-Care Items and Equipment policy identified staff were to clean and disinfect or sterilize reusable or durable medical equipment (DME) between residents.