DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 29, 2022

Administrator
Park River Estates Care Center
9899 Avocet Street Northwest
Coon Rapids, MN 55433

RE: CCN: 245448
Cycle Start Date: February 25, 2022

Dear Administrator:

On April 14, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 29, 2022

Administrator
Park River Estates Care Center
9899 Avocet Street Northwest
Coon Rapids, MN 55433

Re: Reinspection Results
Event ID: 0SSZ12

Dear Administrator:

On April 14, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 25, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2022

Administrator
Park River Estates Care Center
9899 Avocet Street Northwest
Coon Rapids, MN 55433

RE: CCN: 245448
Cycle Start Date: February 25, 2022

Dear Administrator:

On February 25, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an E tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 25, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 25, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. BUILDING _____ B. WING _____	C 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIVER ESTATES CARE CENTER	**9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/22/22-2/25/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/22/22-2/25/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5448062C (MN80244). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		4/11/22

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

Electronically Signed | 03/24/2022

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.

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F 554	Continued From page 1 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, the facility allowed 1 of 1 resident (R52) reviewed for self-administration of medications, to self-administer medications after an interdisciplinary assessment identified that this was not clinically appropriate for the resident. This failure created the potential for medication errors related to the inappropriate self-administration of medications. Findings include: R52's quarterly Minimum Data Set (MDS) identified cognitively intact with diagnosis of heart and kidney failure. R52 required extensive staff assistance for most activities of daily living (ADL's). R52's physicians order for February 2022, included an order for Xopenex (a nebulized mist breathing medication) solution three times a day via nebulizer. R52's Self-administration of Medications assessment dated 12/2/21, included, "She states she takes too many medications and would not know where to start." The form identified R52 would not self-administer any medications. During an observation on 2/2/22, at 11:20 a.m. R52 was in her room alone receiving a nebulized mist treatment.	F 554	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. The Director of Nursing has reviewed and updated policies and procedures to ensure residents are assessed in a timely manner for self-administration of medications. New nebulizer technology has been ordered which requires less time for administration of nebulizer treatment. Nursing staff education will be complete by 4/11/2022. Audits will be completed 5x's per week for a minimum of 4 weeks and will decrease to 1 to 2 x's per week once 100% compliance has been achieved for two consecutive weeks. Results will be reviewed by QAPI for the next 6 months or until 100% compliance is confirmed through two quarters.	

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F 554	Continued From page 2 During an observation on 2/24/22, at 10:20 a.m. R52's nebulizer machine was noted to be running with the medication delivery set-up draped over her rolling walker. R52 stated she received a breathing treatment three or four times a day. The nurse brings in the medication and puts it in the nebulizer medication cup and then turns it on and leaves the room while it is running. The nurse will return in about 10 minutes or so to turn it off. R52 could not recall being assessed to do this independently. During an observation on 2/25/22, at 11:05 a.m. of R52 receiving her nebulizer, licensed practical nurse (LPN)-A placed the medication in the medication cup, placed the nebulizer mask on R52 and stated she would return in, "approximately 10 minutes." LPN-A then left the room while R52 self-administered the nebulizer treatment. During an interview on 2/25/22, at 10:30 a.m. LPN-A stated that after she sets up R52 with her nebulizer, she will leave R52 for approximately 10-15 minutes while the nebulizer runs. LPN-A stated R52 will usually just watch TV or do her crafts while receiving the nebulizer. During an interview on 2/25/22, at 11:30 a.m. LPN-A stated the normal process for self-administration of medication would be the resident would be assessed on admission and if they were alert and oriented they could self-administer medications. LPN-A did not know if R52 had been assessed as safe to self-administer her nebulizer medications. During an interview on 2/25/22, at 12:15 p.m. the	F 554		

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F 554	Continued From page 3 director of nursing (DON) stated residents are assessed on admission, at a minimum, whether they can or want to self-administer medications. The DON was aware R52 was assessed as not appropriate for self-administration of medications and stated the nurse should have stayed with R52 while she was receiving the medication. Review of the facility's policy titled, Self-Administration of Drugs, revised 2/2022, included, "If a resident chooses to self-administer drugs, the interdisciplinary team must assess the residents cognitive, physical, and visual abilities to carry out this responsibility." The policy further noted, "The self-administration of medication assessment will be completed by licensed nursing personnel for on-going compliance."	F 554		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to label/date respiratory care equipment and protect nebulized mist treatment (NMT) equipment ("set up" - including the breathing mask, medication cup and tubing), from environmental elements for 1 of 3 residents (R52) reviewed for respiratory care. The failure	F 695	The Director of Nursing and Infection Control Practitioner have reviewed and updated policies and procedures related to the cleaning, labeling, maintenance and storage of nebulizer equipment. Nursing staff re-education will be complete by 4/11/2022. Audits will be completed 5x's	4/11/22

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F 695	Continued From page 4 created the potential for outdated respiratory supplies to be used and cross contamination of NMT set-ups. Findings include: The facility policy titled, Cleaning and Maintenance of Respiratory Equipment, dated 3/22/04 and revised 02/2022, indicated under, Nebulizer Machine and Equipment, "1. Procedure should be followed after nebulizer treatment while wearing gloves; 2. Disconnect mouthpiece or mask from nebulizer tubing; 3. Rinse the nebulizer and mouthpiece or mask with hot water and let pieces air dry." Under "Oxygen Tubing and Masks," the policy included, "New tubing and masks are to be labeled with paper tape. The night nurses initial, resident's name, and date is to be written on the label." R52's quarterly Minimum Data Set (MDS) dated 12/24/21, identified cognitively intact and had heart failure. R52's physician orders for February 2022, included an order for Xopenex (breathing medication) solution three times a day for chronic respiratory failure. The medication was to be giver via nebulizer medication treatment (NMT). During an observation on 2/22/22, at 12:40 p.m. R52's whole NMT equipment set up, which included the breathing mask, medication cup and tubing, was observed to not be dated and was left exposed to the environment. Condensation was observed in the medication cup. During an observation on 2/24/22 at 7:30 AM, R52 was observed in bed and appeared to be	F 695	per week for a minimum of 4 weeks and will decrease to 1 to 2 per week when 100% compliance is achieved for 2 consecutive weeks. Results will be reviewed quarterly by QAPI for the next 6 months or until 100% compliance is confirmed through two quarters.	

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F 695	Continued From page 5	F 695		

sleeping. The NMT mask set up was observed still put together with the medication cup attached, not protected from environmental factors, in the wastebasket by R52's bed.

During an observation and interview with R52 on 2/24/22, at 10:20 a.m. the NMT machine was observed running upon entrance to her room and during the interview. The equipment for the finished respiratory treatment was observed draped over R52's rolling walker. R52 stated she had put the call light on for the nurse to turn the machine off. During the interview with R52, licensed practical nurse (LPN)-B came into the room, turned off the NMT machine, and with her bare hands picked up the NMT equipment, removed the medication cup, rinsed it out in the bathroom sink and then placed it on a paper towel on the nightstand.

During an observation on 2/25/22, at 9:55 a.m. of R52's room, the NMT set up was observed laying on a paper towel on the nightstand; however the NMT set up was not observed in a protective covering protected from environmental factors or label/dated.

During an interview on 2/25/22, at 10:30 a.m. LPN-A stated the NMT set up was, "usually changed every 2 weeks," but was unable to state when the last time the current NMT set up was changed for R52. LPN-A also stated day shift usually changes the NMT set up. LPN-A was unable to state how she would verify the current NMT set up was recently changed but stated, "usually it's dated somewhere on the set up." LPN A verified the NMT set up which included the breathing mask, medication, and tubing, was not dated.

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F 695	Continued From page 6 During an interview on 2/25/22, at 12:15 p.m. the director of nursing (DON) stated the NMT set up should be taken apart and cleaned, then left to dry in between treatments. The DON also stated the NMT set up should be, at the very least, dated.	F 695		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or	F 888		3/21/22

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F 888	Continued From page 7 telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;	F 888		

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F 888	Continued From page 8 (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. BUILDING _____ B. WING _____	C 02/25/2022

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F 888	Continued From page 9 for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 2 of 162 staff (DA-A and DA-B) received COVID-19 vaccinations or were provided a medical or religious exemption. This was a 99.8% vaccination rate. This practice created the potential for the spread of the COVID-19 virus. Findings include: Review of the facility policy titled, Vaccination Policy, dated 1/15/22, included, "to require all employees to be vaccinated against COVID-19." "Only employees with valid medical or religious exemption will be allowed to remain unvaccinated." 1. Review of the undated, Exemption List, provided by the facility on 2/24/22, revealed Dietary Aide (DA) B's name was on the list and under status, the form indicated, "Has not turned in paperwork for med ex[exemption]."	F 888	The Administrator and Infection Control Practitioner have reviewed and updated policies regarding staff COVID vaccinations to ensure 100% of staff are vaccinated or have an approved exemption on record. An up-to-date list of the vaccination and/or exemption status of all staff is available and will be reviewed by administration weekly as part of new hire orientation.	

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F 888	Continued From page 10 During an interview on 2/24/22 at 12:36 p.m. DA-B stated, "I am not vaccinated yet. I want to try to get a medical exemption but doubt I'll get it." DA-B had been working routinely. 2. Review of the undated, Exemption List, provided by the facility revealed DA-A's name was on the list and under status, the form indicated, "Has not provided any documentation." During an interview on 2/22/22, at 5:10 p.m. DA A started, "I am fully vaccinated." During an interview on 2/23/22, at 4:50 p.m. the administrator was asked about the vaccination status of these two current employees. The administrator stated, "[DA-A] was hired on 1/19/22, and came in the door saying he was fully vaccinated. He has not provided the proof. He stated that he was not provided a card because he was one of the first to get vaccinated." The administrator added that DA-B had been on a leave of absence and had just returned to work. The administrator stated DA-B was trying to get a medical exemption but had not received anything yet. The administrator stated, "Under normal circumstances they [the two unvaccinated staff] would be suspended. They have not been suspended because we need the staff."	F 888		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2022

Administrator
Park River Estates Care Center
9899 Avocet Street Northwest
Coon Rapids, MN 55433

Re: State Nursing Home Licensing Orders
Event ID: 0SSZ11

Dear Administrator:

The above facility was surveyed on February 22, 2022 through February 25, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00010	A. BUILDING: _____ B. WING _____	C 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/22/22-2/25/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. In addition a complaint investigation was completed: The following complaint was found to be UNSUBSTANTIATED: H5448062C (MN80244). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		4/11/22

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21390	Continued From page 3 current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 2 of 162 staff (DA-A and DA-B) received COVID-19 vaccinations or were provided a medical or religious exemption. This was a 99.8% vaccination rate. This practice created the potential for the spread of the COVID-19 virus. Findings include: Review of the facility policy titled, Vaccination Policy, dated 1/15/22, included, "to require all employees to be vaccinated against COVID-19." "Only employees with valid medical or religious exemption will be allowed to remain unvaccinated." 1. Review of the undated, Exemption List, provided by the facility on 2/24/22, revealed Dietary Aide (DA) B's name was on the list and under status, the form indicated, "Has not turned in paperwork for med ex[exemption]." During an interview on 2/24/22 at 12:36 p.m. DA-B stated, "I am not vaccinated yet. I want to try to get a medical exemption but doubt I'll get it." DA-B had been working routinely. 2. Review of the undated, Exemption List, provided by the facility revealed DA-A's name was on the list and under status, the form indicated, "Has not provided any documentation."	21390	Corrected.	

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21390	Continued From page 4 During an interview on 2/22/22, at 5:10 p.m. DA A started, "I am fully vaccinated." During an interview on 2/23/22, at 4:50 p.m. the administrator was asked about the vaccination status of these two current employees. The administrator stated, "[DA-A] was hired on 1/19/22, and came in the door saying he was fully vaccinated. He has not provided the proof. He stated that he was not provided a card because he was one of the first to get vaccinated." The administrator added that DA-B had been on a leave of absence and had just returned to work. The administrator stated DA-B was trying to get a medical exemption but had not received anything yet. The administrator stated, "Under normal circumstances they [the two unvaccinated staff] would be suspended. They have not been suspended because we need the staff." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or infection preventionist (IP) could review policies and procedures to ensure the facility's vaccination rate is 100% for vaccinated and approved exempted staff. An audit could be completed and staff who are not vaccinated followed up with to ensure they do not work unless vaccinated or have an approved exemption. Audits could be ongoing for newly hired staff. TIME PERIOD FOR CORRECTION: 7 days.	21390		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of	21565		4/11/22

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21565	Continued From page 5 care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, document review, the facility allowed 1 of 1 resident (R52) reviewed for self-administration of medications, to self-administer medications after an interdisciplinary assessment identified that this was not clinically appropriate for the resident. This failure created the potential for medication errors related to the inappropriate self-administration of medications. Findings include: R52's quarterly Minimum Data Set (MDS) identified cognitively intact with diagnosis of heart and kidney failure. R52 required extensive staff assistance for most activities of daily living (ADL's). R52's physicians order for February 2022, included an order for Xopenex (a nebulized mist breathing medication) solution three times a day via nebulizer. R52's Self-administration of Medications assessment dated 12/2/21, included, "She states she takes too many medications and would not know where to start." The form identified R52 would not self-administer any medications. During an observation on 2/2/22, at 11:20 a.m. R52 was in her room alone receiving a nebulized mist treatment. During an observation on 2/24/22, at 10:20 a.m.	21565	Corrected.	

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21565	Continued From page 6 R52's nebulizer machine was noted to be running with the medication delivery set-up draped over her rolling walker. R52 stated she received a breathing treatment three or four times a day. The nurse brings in the medication and puts it in the nebulizer medication cup and then turns it on and leaves the room while it is running. The nurse will return in about 10 minutes or so to turn it off. R52 could not recall being assessed to do this independently. During an observation on 2/25/22, at 11:05 a.m. of R52 receiving her nebulizer, licensed practical nurse (LPN)-A placed the medication in the medication cup, placed the nebulizer mask on R52 and stated she would return in, "approximately 10 minutes." LPN-A then left the room while R52 self-administered the nebulizer treatment. During an interview on 2/25/22, at 10:30 a.m. LPN-A stated that after she sets up R52 with her nebulizer, she will leave R52 for approximately 10-15 minutes while the nebulizer runs. LPN-A stated R52 will usually just watch TV or do her crafts while receiving the nebulizer. During an interview on 2/25/22, at 11:30 a.m. LPN-A stated the normal process for self-administration of medication would be the resident would be assessed on admission and if they were alert and oriented they could self-administer medications. LPN-A did not know if R52 had been assessed as safe to self-administer her nebulizer medications. During an interview on 2/25/22, at 12:15 p.m. the director of nursing (DON) stated residents are assessed on admission, at a minimum, whether they can or want to self-administer medications.	21565		

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21565	Continued From page 7 The DON was aware R52 was assessed as not appropriate for self-administration of medications and stated the nurse should have stayed with R52 while she was receiving the medication. Review of the facility's policy titled, Self-Administration of Drugs, revised 2/2022, included, "If a resident chooses to self-administer drugs, the interdisciplinary team must assess the residents cognitive, physical, and visual abilities to carry out this responsibility." The policy further noted, "The self-administration of medication assessment will be completed by licensed nursing personnel for on-going compliance." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of nebulzier medications; then provide staff education. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		

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	245448	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/24/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/24/2022. At the time of this survey, Park River Estates Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/31/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/24/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIVER ESTATES CARE CENTER	**9899 AVOCET STREET NORTHWEST** **COON RAPIDS, MN 55433**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Park River Estates Care Center is a 1-story building without a basement. The building was constructed at three different times. The original building was built in 1967 and was determined to be of Type II(222) construction. In 1988, an addition was constructed as the South Wing that was determined to be of Type II(111) construction. Finally, another addition was added in 1992 to the East Wing and was determined to be of Type II(111). The facility was surveyed as one building because the original building and the two	K 000		

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K 000	Continued From page 2 additions conform to the lower protected construction type allowed for existing buildings. Multiple smoke compartments separate the building for a shelter-in-place strategy. The facility is fully protected throughout by an automatic fire sprinkler system. In addition, the facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 82 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not maintain the means of egress to be free of combustible obstructions per NFPA 101 (2012 edition), Life Safety Code, sections 7.1.10.1, 7.1.10.2.1, and 19.2.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 211	The means of egress was immediately cleared of materials. All staff will be re-educated on keeping means of egress free of all obstructions. Maintenance director will audit weekly.	4/11/22

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	245448	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/24/2022**

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K 211	Continued From page 3 On 02/24/2022 at 12:21 PM, an observation revealed that there was combustible storage found in the egress enclosure by the chapel exit. An interview with the Facility Maintenance Engineer verified this finding at the time of discovery.	K 211		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, that facility did not maintain smoke barrier walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, and 8.5.6 through 8.5.6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/24/2022 at 10:26 AM, observation revealed that there was a penetration around a duct in the	K 372	The deficient finding was repaired on 2/25/2022 with fire resistant caulk. All vendors are required to fill/repair any penetrations following any work done in the building with appropriate fire resistant materials. This will be audited by maintenance following any work in the building.	4/11/22

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K 372	Continued From page 4 smoke barrier wall above the smoke barrier doors by the Dining Room. An interview with the Facilities Maintenance Engineer verified this finding at the time of discovery.	K 372		