DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2981

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00010

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245448**
2.STATE VENDOR OR MEDICAID NO.
(L2) **426040600**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK RIVER ESTATES CARE CENTER**
(L4) **9899 AVOCET STREET NORTHWEST**
(L5) **COON RAPIDS, MN** (L6) **55433**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/13/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Brenda Fisher, Supervisor 04/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/05/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/08/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5448

Electronically Delivered: April 14, 2015

Mr. Thomas Pollock, Administrator
Park River Estates Care Center
9899 Avocet Street Northwest
Coon Rapids, Minnesota 55433

Dear Mr. Pollock:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 27, 2015 the above facility is certified for:

99 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 99 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 13, 2015

Mr. Thomas Pollock, Administrator
Park River Estates Care Center
9899 Avocet Street Northwest
Coon Rapids, Minnesota 55433

RE: Project Number S5448022

Dear Mr. Pollock:

On March 12, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 26, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 13, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 31, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 26, 2015, effective March 27, 2015 and therefore remedies outlined in our letter to you dated March 12, 2015, will not be imposed.

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 contact me if you have any questions about this electronic notice.

Sincerely,

Anne K. Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245448	A. Building B. Wing	4/13/2015

Name of Facility	Street Address, City, State, Zip Code
PARK RIVER ESTATES CARE CENTER	9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **03/27/2015**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **03/27/2015**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **03/27/2015**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **03/27/2015**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **03/27/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/27/2015**
ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **03/27/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/27/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/AK	04/13/2015	10562	04/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/26/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245448	A. Building B. Wing **01 - MAIN BUILDING 01**	3/31/2015

Name of Facility	Street Address, City, State, Zip Code
PARK RIVER ESTATES CARE CENTER	9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0017	**03/27/2015**	ID Prefix Reg. # **NFPA 101** LSC K0069	**03/27/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	04/13/2015	28120	03/31/2015
CMS RO				

Followup to Survey Completed on: 2/27/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245448	02 - NEW WING	3/31/2015

Name of Facility	Street Address, City, State, Zip Code
PARK RIVER ESTATES CARE CENTER	9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0017	03/27/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	04/13/2015	28120	03/31/2015
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
2/27/2015	

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2981

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00010

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245448**

2.STATE VENDOR OR MEDICAID NO.
(L2) **426040600**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK RIVER ESTATES CARE CENTER**
(L4) **9899 AVOCET STREET NORTHWEST**
(L5) **COON RAPIDS, MN** (L6) **55433**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/26/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Bruce Melchert, HFE NE II 03/31/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/07/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 12, 2015

Mr. Thomas Pollock, Administrator
Park River Estates Care Center
9899 Avocet Street Northwest
Coon Rapids, Minnesota 55433

RE: Project Number S5448022

Dear Mr. Pollock:

On February 26, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 7, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 7, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 26, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 26, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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 _____	02/26/2015

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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		3/27/15

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

Electronically Signed | 03/20/2015

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and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the proper Medicare liability notice was given to 5 of 5 residents (R117, R37, R103, R28, R100) reviewed for liability notice and appeal rights. Findings include: R117's Centers for Medicare and Medicaid (CMS) Notice of Medicare Non-Coverage (CMS-10123) dated 10/13/14, indicated R117's skilled rehabilitation services ended on 10/14/14. R117's signature was obtained, to reflect the notification was received and understood, with a signature date of 10/13/14. The resident received the discharge noted one day before services ended and not two days as required. R117 discharged from the facility on 10/15/14.	F 156	The facility will issue a CMS-10123 notice to all patients covered by Medicare at least 2 days prior to services ending. This includes patients being discharged home or staying long term. The Medicare nurse is responsible for issuing the notice according to the CMS guidelines and to document on the log summarizing the notices. This includes the patients name, the date the notice was given and when the services end. The log will be reviewed at the next four weekly Medicare meetings for compliance. The results will be reviewed the next QAPI meeting in April 2015. The Medicare nurse will monitor for compliance.	

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F 156	Continued From page 3 R37's medical record identified R37 did not receive a CMS-10123, after the facility determined she no longer qualified for Medicare beginning 2/20/15. R37 received the SNF (skilled nursing facility) Determination On Continued Stay that indicated R37 had reached her maximum potential, would remain in the facility, and continued on a Restorative Nursing Ambulation Program. R103's medical record identified R103 did not receive a CMS-10123 after the facility determined she no longer qualified for Medicare beginning 11/6/14. R103 received the SNF Determination On Continued Stay that indicated R103 had reached her maximum potential, would remain in the facility, and would continue on a Restorative Nursing Services. R28's medical record identified R28 did not receive a CMS-10123 after the facility determined he was no longer qualified for Medicare beginning 2/20/15. R28 received the SNF Determination On Continued Stay that indicated R28 had reached his maximum potential, would remain in the facility, and would continue a Restorative Nursing Ambulation Program. R100's medical record identified R100 did not receive a CMS-10123 after the facility determined he was no longer qualified for Medicare beginning 12/24/14. R100 received the SNF Determination On Continued Stay that indicated R100 had reached maximum potential, would remain in the facility, and would continue on a Restorative Nursing Program. During interview on 2/25/15, at 2:16 p.m.	F 156		

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F 156	Continued From page 4 registered nurse (RN)-B stated they only give the CMS-10123 for resident who are discharging from the facility. They do not give this to resident who are planning on staying in the facility for long term. Further, RN-B stated she was not aware that residents that were staying in the facility were required to receive both forms, the Notice of Medicare Non-Coverage (CMS-10123) and the SNF Determination On Continued Stay. During interview on 2/26/15, at 10:44 a.m. RN-C stated we only give the SNF Determination On Continued Stay if the resident is staying in the facility, we do not give the CMS-10123. Further, RN-C stated she was not aware that residents were required to receive both forms. When interviewed on 2/26/15, at 9:18 a.m. the administrator stated they did not have a policy on liability notices and they follow the instructions on the forms to explain the procedure and the appeal process to our residents. Further, the administrator stated he was aware of the liability notice process, and felt the facility had followed it correctly.	F 156		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		3/27/15

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F 164	Continued From page 5 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide visual privacy for 1 of 1 residents (R5) whose body was exposed and visible from the hallway during personal cares. Findings include: R5's quarterly Minimum Data Set (MDS) dated 1/16/15, identified diagnoses of depression and osteoporosis. The MDS indicated she was cognitively intact and needed assist of one with toileting and transfers. R5's care plan dated 10/03/14, indicated she needs extensive assistance to use the toilet and staff were to assist with peri-care as needed. During observation, 2/24/15, at 8:55 a.m. R5 was	F 164	Privacy is provided for residents when cares are being done or when assisted with toileting. All staff are educated on the importance of resident's privacy. Nursing staff is educated upon hire and annually that privacy curtains and residents room/bathroom doors are to be closed while provided care. All nursing staff shall receive the privacy policy by 3/27/15. R5's privacy will be monitored by the DON for compliance. Random checks will be done and documented on at least one wing per day for at least seven days to assure privacy with cares and toileting assistance. The documented checks will be presented at the next QAPI meeting in April 2015. The DON is responsible for compliance.	

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sitting in her wheelchair in the bathroom with her call light on. At 9:25 a.m. nursing assistant (NA)-L entered R5's room and turned R5's call light off. NA-L proceed to place R5 on the toilet with the bathroom room door wide opened and the resident's room door to the hallway was also wide open. NA-L then stood R5 up in the bathroom, with her back facing the room, provided peri-care, and exposed R5's buttocks. NA-L made no attempts to close the bathroom door while she assisted R5 to provide visual privacy. R5's exposed peri area and buttock could be seen from the hallway where residents and visitors could walk by.

During interview 2/24/15, at 10:14 a.m. NA-L stated she did leave the bathroom door while toileting R5 and that she was "just so busy" and did not close the door.

During interview 2/25/15, at 2:16 p.m. the director of nursing (DON) stated the staff should have closed R5's door while providing toileting assistance.

During interview 2/26/15, R5 stated " I don't know why they don't shut my door there are times I have to remind the staff to shut the door when I am in the bathroom."

Review of the facility Privacy During Cares Policy and Procedure, revised 12/2012, indicated "Residents have the right to respectfulness and privacy during medical care and personal care, except as needed for resident safety or assistance. Residents have the right to privacy, individuality and cultural identity as related to their social, religious and psychosocial well-being. Facility shall respect the privacy of a resident's

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F 164	Continued From page 7 room by knocking on the door and seeking consent before entering, except in an emergency." The policy further indicated "doors are to be closed during the care of a resident."	F 164		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly and effectively resolve individual grievances, related to residents being dressed timely, toileting, call light response time and cold food temperatures, for 2 of 5 residents (R54 and R59) family with complaints, and for 1 of 1 confidential interview (CI-A) complaints in the sample who verbalized unresolved grievances by the facility. Findings include: R54's quarterly Minimum Data Set (MDS) dated 12/26/14, identified her cognition was moderately impaired, R54 required extensive assistance with transfers, toileting and person hygiene. R54 needed supervision with eating and diagnoses includes hemiplegia, hemiparesis and depression. During an interview on 02/25/2015 at 11:30 a.m. family member (FM)-D said, "They can't get her ready to go to mass on Sunday on time". He	F 166	The facility does have in place a Problem Resolution-Grievance Policy, Procedure and form available to all residents and family members. The form is located at the nursing station and across from the receptionist desk. The policy, procedure and form will also be included in the admission packet and provided at each care conference. An article will in the April 2015 facility newsletter informing residents and families of the grievance form. All grievances written or verbal will be logged in a book in the Social Service office. The resolution will be logged and discussed with the resident/family member reporting the grievance by the department supervisor involved in the grievance. All grievances will be discussed weekly at the management stand up meeting. On the nursing assistant assignment sheet for R54, it does and has indicated the need to up for church on Sunday. The DON will follow up	3/27/15

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F 166	Continued From page 8 went on to say they only hold mass twice a week but she is not ready to go by the time it starts at 10:30 a.m. most of the time. I don't know why they can't have her ready by then, she had been a resident here for two years. It has not changed. He said that he has expressed his concerned misgivings to staff at care conferences. He said the response from staff is that they will discuss the concern with the administrator. He said he has not heard anything about a resolution from administration and she (R54) still isn't up on time for mass. FM-D said "we don't like it", we enter mass 5-10 minutes late often. "Religion is important to us" FM-D stated they have limited staff here, and they need to make sure there is enough staff to take care of the residents. During observation on 02/25/2015 from 1:24 to 1:35 p.m. R54 was sitting in the dinning room and offered no complaints. An unknown activity staff moved R54 from the dining room to her room. An interview on 02/25/2015 at 1:56 p.m. with NA-D stated R54 does not wait while I'm here. I know her routine and I know how to take care of her. We try to have her up for church but I'm not here everyday. During an interview on 02/26/2015 at 11:24 a.m. licensed practical nurse (LPN)-A stated I have not gotten any instruction to get R54 up at a certain time. I usually direct complaints to social services or the administrator. I haven't been giving residents or families the complaint form. Review of R54's care plan dated 10/21/14 directed staff to, "Assist res [resident] to church events within facility; her family may join her. Esp	F 166	weekly with the family of R54 & R59 until resolved. All grievance forms are submitted to the administrator for his final review. The administrator is also exploring a new automated call light system to track call lights. Social service is responsible for providing grievance forms to residents/families upon admission and at care conferences. All grievances, verbal and written will be tracked by social services. The tracked grievances will be reviewed at the next QAPI meeting in April 2015. The Director of Social Services is responsible for compliance.	

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[especially] on sun [Sunday] AM (have res out of bed&in w/c [wheelchair]).

On 02/25/2015 at 3:01 p.m. social services (SS)-A said she didn't have any grievances for the past six months. SS-A said she does not track grievances, each department follows up on their own concern. " I don't feel that every concern is a grievance" if they don't fill out a grievance form it is a concern. The form is available at the nurses stations, and at the front desk. SS-A said the departments do not report their results of grievances to any committee and does not remember a complaint from FM-D.

An interview with the director of nurses (DON) on 02/26/2015 at 10:58 a.m. said "I have an open door policy." She does not necessarily encourage a form but I always take verbal complaints and try to get back to the family. She doesn't have any documentation of her response to these concerns. I let social services know of the resolution and assume social services is in contact with the resident/family member too. DON stated, she had heard about complaint of going to church late and I put it on the nursing assistants (NA)'s worksheet. Review of the NA's worksheet with DON at this time identified that R54 was to be up by 9:00 a.m. for breakfast and for church on Sundays. The DON stated she looked back and this note had been placed on the NA's worksheet since October 2014. This was also listed at the nurses station too. She was unaware this was still a concern.

Review of the undated and untitled NA's worksheet identified, " ..MUST BE ^ FOR BRKF [breakfast] ^ by 9a. sun [Sunday] for church."

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R59's quarterly Minimum Data Set (MDS) dated 12/12/14, indicated she had moderately impaired cognition, needed extensive assistance with activities of daily living (ADL's) and was occasionally incontinent of urine. R59's care plan, dated 1/1/15, identified a problem of "occ-freq [occasionally-frequently] inc [incontinent] of bladder, requires 2 staff assist with toileting process in the BR [bathroom]..." The interventions were listed as, "OCC-FREQUENTLY INCONTINENT; Strongly encourage & 2 staff assist res [resident] to BR during the day Q [every] 2-3 hrs [hours] & prn [as needed] res request. Prove inc [incontinence] care as needed..."

During interview 2/25/15, at 5:34 p.m. R59's family member (FM)-F stated she had ongoing, unresolved concerns but FM-F biggest concern was the response time to the call lights. FM-F stated where R59's room was located, staff were unable to see the call light when it was on. FM-F stated, it is like (R59's) room is "out of site, out of mind." She has told several nurses, and also the head nurse, about her concerns but "nothing seems to get better." FM-F then stated, that family goes to the facility about long call light response all the time, because, "[R59] had wet herself, and that should not happen, if the staff would just take her to the bathroom." FM-F also stated, when we are here, we get upset and "Just take her to the bathroom ourselves." FM-F further stated staff were always getting the residents to the dining room late, and her food was often cold.

During interview 2/26/15, at 11:00 a.m. social worker (SW)-A stated she was aware of the

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family concern of the call light not easily seen due to the location of R59's room. She stated they had put a light in the hall so the staff could see if any of the lights are on in that area.

During interview 2/26/15, at 11:25 a.m. the DON stated she was aware of the concerns the family had with her toileting and the staff are to be writing down when they toilet R59. The DON stated the staff give the sheets to medical records and they store them. The toileting sheets for R59 were requested on two separate occasions and were never provided to the survey team.

During a confidential interview (CI)-A on 02/26/2015, at 10:35:25 a.m., CI-A stated she has a concern about a resident who has been in the facility for several years. CI-A complained, there were "just not enough help in the facility, especially on the weekends." The resident was not getting their cares completed as they should and they were not getting properly shaved. There were time that they brought the resident to the bathroom, because, "they just leave [him/her] because I am here." CI-A added, "I feel like I work here," and has brought these concerns to the resident's care conferences, and they tell me to let the staff know my concerns right away, which they do. CI-A stated, "I thought that was the reason for the care conferences, so I could tell them my concerns; but they put it right back on me to deal with." CI-A further stated, "I quit going to the conferences, because they don't deal with my concerns."

Although the facility was aware of FM-D, and FM-F grievances, the facility did not provide a resolution to these families' expressed concerns.

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F 166	Continued From page 12 Review of the facility undated policy entitled Problem Resolution-Grievance Procedure indicated, "When an issue presents itself, please contact the staff representative listed below immediately." The policy listed nine staff representatives and a phone number for each person. The policy further identified the "problem resolution form-grievance forms" are available at each nursing station, the social service office and the receptionist.	F 166		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to honor preferences for daily routines, and visitors for 1 of 3 residents (R37) reviewed for choices. Findings include: R37's admission Minimum Data Set (MDS), dated 1/16/15, identified R37 had intact cognition, and it was "very important" for her to choose her own bedtime, and it was "very important" to have her family or close friend involved in discussion about her cares.	F 242	The facility does honor preferences for residents and patients. R37 does have a roommate, R16. R37 has a spouse R28 also living at Park River Estates Care Center. Both R37 and R16 have strong preferences which neither want to give in. As indicated, the goal is to have R37 and R28 live together. The next best option is to have either spouse in a private room. R37 was offered a private room and refused to move. R28's roommate's family was asked about moving to another room and they declined. A meeting was held	3/27/15

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F 242	Continued From page 13 During interview on 2/24/2015 at 9:27 a.m., R37 stated she had been "told by staff" she needs to turn her television and room lights off at 10:30 p.m. every night, "because it upsets her roommate (R16)." Further, R37 said that being told to turn her lights and TV off at a certain time was "frustrating," and also that it "upset" her. My roommate just wants everything her way and I think staff could do more. The staff know we (roommate and R37) do not get along. When interviewed on 2/25/15, at 11:26 a.m., family member (FM)-R and FM-S stated R37 typically went to bed "around the midnight hour" when they lived at home, prior to coming to live at the nursing home. R37 had often voiced frustration and disapproval to FM-R and FM-S of having to turn off the TV and lights at a certain time, and often felt treated like a child. Further, R37's spouse, R28 who currently lives at the facility has certain hours in which he was able to visit R37 in her room. He leaves the room when roommate (R16) uses the bathroom and leaves the room from after lunch until 4:00 p.m., and leaves again at 8:00 p.m. He (R28) was told this is what he has to do. FM-S stated we were told by the facility this was the way it had to be, even though as a family do not like it. This schedule of R28 only seeing R37 has increased R37's frustration and stress since coming to live at the nursing home. FM-R stated they have been married for over 60 years, and they are always together. The facility making these restrictions of R28 only being able to visit R37 in her room during specific times, was very upsetting to R37. The goal was for R37 and R28 was to be able to share a room, but they are waiting for this to happen which may take a long time. FM-R stated	F 242	with R16, R37, R28 and family members to reach a compromise. Progress was very small. The TV policy has worked in the past to resolve roommate issues considering there are other areas in the building to watch TV. The Director of Social Services will offer a double room to R37 and R28 when one becomes available since a private room was not acceptable to R37. The Director of Social Services also contacted the local Ombudsman for assistance in resolving R37 and R16 issues. The Director of Social Services will have similar meeting with all future residents in double occupancy rooms to discuss individual preferences and have one or more resolutions agreed upon. The issues will be logged by the social service department. Choices and preferences will also be discussed and updated at all care conferences for all residents. The Director of Social Services will remind residents at care conferences if they have issues with their roommates or anything else. The grievances regarding roommates will be reviewed at the next QAPI meeting in April 2015. The Director of Social Services is responsible to monitor for compliance.	

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that R37 has difficulty seeing, and wants to stay in her room, because she is familiar with the surroundings and is more comfortable. FM-S stated (R38) doesn't want to be treated "like a kid" these rules make "her feel like a child."

Review of R37's nursing progress notes, dated (late entry) 2/12/15, identified, "Resident upset when writer [facility staff] told her TV needed to be turned off...told her room-mate can not sleep c [with] lights and TV on." Further, R37 had turned the TV off at 11:45 p.m., but then turned a radio on. An untitled document, dated 2/17/15, located in West Treatment Book (which staff use to communicate resident needs to each other) identified, "We all need to try and work on a routine for [R37] and [R28]. They can visit after breakfast in her room. No visiting in her room after lunch for a few hours to allow some down time. [R37] and [R28] could visit in her room after 4:00 p.m.. After dinner they can visit until about 8:00 p.m. This should allow [R37]'s roommate sometime to get ready for bed. Thank You, Social Service."

When interviewed on 2/25/15, at 3:05 p.m., a social service designee (SS)-A stated she was aware of the desire for R37 and R28 to have a shared room, but the facility did not have an open room for them to share as desired. Further, it could take several months or years for a room to open on the desired wing for them to be able to share a room.

During interview on 2/26/15, at 9:09 a.m. R37 stated the facility was trying to arrange for her and R28 to share the same room, but would have to wait for another "resident to die", for a space to be available. I do not like that R27 can only visit

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F 242	Continued From page 15 during certain hours. Further, R37 stated she had been told by staff to watch TV in the lounge area after 10:30 p.m., however she had poor vision, was fearful to be out of her room without a call light that late in the evening and prefers to stay in her room because she is familiar with the surroundings due to her poor vision. When interviewed on 2/26/15, at 3:28 p.m. with the director of nursing, SSD-A and SSD-B, SSD-A stated R37's roommate (R16) was offered a different room a couple weeks prior, but declined to move. An open room on the facility North wing, had not been offered to R37 because her spouse (R28) would still visit frequently and upset a new roommate. SSD-A stated the facility has a television policy which applied to all residents. When asked if SSD-A and SSD-B had spoken with R37 and R16 (roommate) together so a plan about the television and visiting of R28 could be discussed so a compromise could be reached which would work for both residents. SSD-A and SSD-B, both had no response. SSD-A then stated she was unsure. A facility Television policy, dated 12/3/13, identified, "...all televisions in double occupancy rooms be turned off between the hours of 10:30 p.m. and 6:00 a.m. There are TV's available to watch after 10:30 p.m. in the resident lounge and TCU [transitional care unit] lounge." The policy lacked any reference to honoring a residents choice to remain in their room and watch TV.	F 242		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250		3/27/15

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F 250	Continued From page 16 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide social services for 1 of 1 residents (R52) who wanted to be discharged home. Findings include: R52 admitted to the facility on 09/08/14 per the facility face sheet. R52's quarterly Minimum Data Set (MDS) dated 12/5/14, indicated she was cognitively intact. R52's care plan dated 10/03/14, indicated she had depression related to admission and "Resident has been feeling a little depressed because she had to leave her home.." The care plan further indicated that social services were to meet with family/resident one to one as needed. R52's psychosocial well being care area assessment dated 9/19/14, indicated she had a potential problem due to dementia and decline in activities in daily living and was to be care planed to slow or minimize a decline. R52's chart review indicated a Geriatric Services of Minnesota progress note completed by her nurse practitioner on 1/26/15, which indicated "patient requesting to go home, family also questioning this cognitive eval pending by OT (occupational therapy). A OT Therapist Progress & Discharge Summary dated 02/05/15, indicated she was seen for evaluation and nine treatments for cognitive assessment and safety due to patient request to return home with her son. The	F 250	The facility does provide social services to those patients and residents who want to be discharged home as evidenced by discharging over 135 in 2014. The facility did inform R52 that Senior Linkage Line was contacted as well as her son to explore going home. The son stated that Senior Linkage line did offer R52 services to go home in order to live independently. R52 refused the services. Senior Linkage Line stated that she would not be safe at home without home health services. The son is looking in to assisted living as suggested by the Director of Social Services. Social services will visit with R52 weekly to assist with the adjustment of not being able to return home and living at Park River Estates Care Center. Social services will also meet with all residents who express a loss (i.e. of home, spouse, etc.). The facility will include "Return to Community Brochures" in all admission packets and will be available at all quarterly care conferences. The resident will be asked if they plan on continuing to live here or be discharged. If the preference is discharge, social services will call Senior Linkage Line for assistance. If the result is that the resident is unable to return home, social services will meet with the resident weekly to assist with the grieving process. The facility will	

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F 250	Continued From page 17 cognitive assessments indicate R52 had moderate level dementia. The assessment further indicated "instructed patient in unsafe return to home, requires 24 hour supervision, assist of one with mobility and self cares." During interview 2/25/15, at 1:50 p.m. R52 stated, "The doctor and the therapy are telling me I am senile and I have to stay here. The girls in therapy told me they don't think I will be going home." R52 started crying and stated "It hurts so much I have such a nice home!" R52 then stated she felt they falsified her comments so she can not go home and continued to cry. She then stated she wishes there was someone she could talk to and that she was informed of this decision two weeks ago and no one has come to talk to her about this loss. R52 further stated "I don't even know who the social workers are here." During interview 2/25/15, at 1:58 p.m. with the social service designee (SSD)-A stated she was aware that R52 wanted to go home and OT had informed her she will not be going home. She had not meet with R52 to discuss her concerns and finding of not being able to return home. SSD-A then stated "She [R52] is listed to have a care conference in two weeks and we can talk with her then." She had not met with R52 for any one to one's and the last time social services spoke with her was in December 2014 during her last care conference. During interview 2/26/15, at 10:04 a.m. the occupational therapist (OT)-A stated R52 cognition was tested and they feel she can not return home. The OT further stated we informed her family, nurse practitioner and the facility social workers about R52 not being able to return	F 250	contact the our contracted psychologist for their involvement if needed. The Director of Social Services is responsible to monitor for compliance and will report the number of referrals made to Senior Linkage Line at the next QAPI meeting in April 2015.	

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F 250	Continued From page 18 home. During interview 2/26/15, at 10:54 a.m. (SSD)-B stated she talked with R52 yesterday afternoon (2-25-15) and she cried to me about not being able to go home. SSD-B stated the last time she spoke to R52 was 12/5/14, when she completed her quarterly MDS assessment. Review of the Park River Estates Care Center Job Description- Director of Social Services dated 2/21/00, identified the following responsible for the SSD's. "Overall social service delivery in a long term care setting. Clear and timely communication with colleagues, residents, and families. Effective supervision of social service staff. Facilitates the admission process, works with current residents regarding psychosocial needs, refers to outside agencies as needed, such as medical assistance, and home care agencies. Facilitates care conferences with staff, residents and families. Responsible for enforcement and education regarding the Resident Bill of rights." Although R52 had expressed the desire to go home and was grieving her loss of independence, the facility failed to provide any services to assist her with the grieving process.	F 250		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		3/27/15

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F 314	Continued From page 19 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor, assess, and document the status of a pressure ulcer for 1 of 3 residents (R125) reviewed for pressure ulcers. Findings include: R125's diagnoses, as identified on the care plan (CP) updated 1/21/2015, included failure to thrive, and edema. The admission Minimum Data Set (MDS), dated 1/1/2015, indicated R125 was cognitively intact, and required extensive, physical assistance for bed mobility, transferring, and ambulation. The MDS also indicated R125 was at risk to develop pressure ulcers, and was admitted to the facility with two unstageable (full-thickness tissue loss, in which the base of the ulcer in the wound bed is covered by slough, eschar, or both, preventing visualization of a wound's depth) pressure ulcers on his right rib, below the scapula. A facility High Risk Skin Data Collection tool, dated 12/28/2014, indicated R125's Braden score (a clinical assessment predictor of pressure sore risk) was 17, which identified mild risk. R125's care plan (CP), updated 2/5/2015, identified skin impairments to his right back area, and listed interventions to heal the pressure sores, among which included: "Weekly skin assessment by licensed staff." During an interview on 2/25/2015 at 12:08 p.m.,	F 314	The facility does consistently monitor, assess and document the status of a pressure ulcer. Residents are assessed at the time of admission, re-admission and annually to identify residents that are of high risk for the development of skin issues and pressure ulcers. Treatment for pressure ulcers will be assessed and implemented by the wound nurse. The wound nurse will do weekly documentation on wounds. Two times per week, nursing will document on the wound after they have done the prescribed treatment. When the wound is healed and a maintenance treatment is being done, the nurse will document it in the nurses notes. All residents will have a visual body audit performed weekly by a nurse on their bath day and documented on the bath audit sheets. In absence of the wound nurse, the DON will perform wound rounds. Nursing staff will be educated on the pressure ulcer documentation and the DON will monitor the weekly wound documentation for compliance. The results of the documentation review will be presented at the next QAPI meeting in April 2015.	

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licensed practical nurse (LPN)-A stated he was "Not sure what kind of skin issue [R125] had." LPN-A said he knew R125 was receiving a barrier cream treatment to his bottom, but was unaware of any additional skin concern. After looking in R125's nursing progress notes, LPN-A said there was "no mention" of any open area to R125's bottom, and the most recent skin assessment note in the chart "was from "January 18th, which was about open areas on [R125's] back." LPN-A stated there was nothing more recent [than January 18th] in R125's nurse's notes regarding an assessment of skin or pressure ulcers.

On 2/25/2015 at 12:30 p.m., R125's nurse's notes (NN) from 12/26/2014 to 2/26/2015 were reviewed. The NN dated 12/29/2015 indicated [R125] admitted with open areas on right, mid back over prominent ribs. The proximal site measured 1 centimeter (cm) x 0.8 cm, and the distal site was 0.5 cm x 1 cm. Both sites presented with "cliff edges" with depth of 0.1 cm, and both were 100% slough covered. The NN also indicated the wounds were unstageable. Other NN describing the progress of R125's pressure sores were completed on 12/31/2014, 1/8/2015, 1/14/2015 and 1/18/2015. The nurse's noted indicated the wounds were improving.

R125's weekly body audits were reviewed from 1/7/2015 to 2/28/2015. The audit dated 1/7/2015 indicated R125's "R [right] back OA [open area] treated." An undated audit indicated R125 had a new dressing to "R [right] back wound." A body audit dated 2/11/2015 indicated a concern with a finger abrasion and growth on R125's scalp. The remaining weekly body audits, dated 1/21/2015, 1/28/2015, 2/4/2015, 2/11/2105, 2/18/2105, and 2/28/2015, which were each signed by a licensed

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nurse, all indicated R125's skin was intact. There were no additional nurse's notes, wound notes, or other treatment records found in the medical record that addressed R125's pressure ulcers from 1/18/2015 to 2/26/2015, more than 5 weeks, since the last nurse's note, dated 1/18/2015, regarding the size and status of R125's pressure ulcers.

During an interview on 2/26/2015 at 10:14 a.m., registered nurse (RN)-B reviewed R125's initial assessments, and stated he was admitted with two unstageable pressure ulcers on his back, just below the right shoulder blade. RN-B said the assistant director of nursing (ADON) completed wound rounds every Wednesday, and made progress notes. RN-B stated, that "...typically, there is no one to do that when she is gone." RN-B said a residents' wounds should be continually "monitored, assessed and documented weekly."

During observation on 2/26/2015 at 10:41 a.m., nursing assistant (NA)-B and licensed practical nurse (LPN)-B assisted R125 with routine cares in his room. In the presence of LPN-B, skin observation was made and measurement were completed by LPN-B. R125 presented with two, superficial pressure ulcers located on his back, below the right scapula. The proximal ulcer was 0.3 cm in diameter, with no depth, round in shape with edges approximated; the pressure ulcer had neither odor nor drainage of any kind, and the surrounding skin was dry and intact. This pressure ulcer was encircled by an oblong-shaped, faint, pink area, 3 cm wide and 6 cm in length; there was no unusual warmness present. The distal pressure ulcer was circular in shape, 0.5 cm in diameter, with no depth, and

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wound edges were approximated; there was neither drainage nor odor present, and the surrounding skin was intact and dry. The measurement's of R125's pressure ulcers were nearly identical to those described in the nurse's note dated 1/18/2015. R125's bottom and coccyx areas were dry and intact.

Although a current observation of R125's skin, and review of the progress notes indicated R125's pressure ulcers were healing, the medical record lacked a current assessment of R125's skin. Further, since January 18, 2015, R125's medical record lacked an expected, at least weekly, assessment of progress of his current pressure ulcers.

In an interview on 2/26/2015 at 3:00 p.m., the director of nursing, (DON) stated she realized R125's wound assessments and documentation "were not getting done consistently." The DON said there were "changes coming" in how the facility wound records would be organized, including implementing the electronic records. "However," the DON stated, there should be "weekly documentation in the records, and it has not been completed, but is should be completed."

A review of "Treatment and Prevention of Pressure Ulcers," revised 12/2012, indicated the facility policy was "...to properly identify and assess residents whose clinical conditions increase the risk for development of skin issues, and pressure ulcers..." and "...to provide appropriate treatment measures for pressure ulcers..." The policy listed under "procedure" IV: Chart at a minimum on the Weekly Wound Progress sheet.

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F 364	Continued From page 23	F 364		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure vegetables were cooked in a manner to maintain palatability for 6 of 87 residents (R124, R16, R147, R7, R59 and R38) who received food from the kitchen and had food complaints. Findings include: R124's admission Minimum Data Set (MDS) dated 1/1/15, indicated he was cognitively intact. During interview on 2/23/15, at 6:52 p.m. R124 stated "the food lacked seasoning, its very bland and the food is cold." R16's annual MDS dated 12/12/14, indicated she was cognitively intact. During interview on 2/24/15, at 8:55 a.m. R16 stated she "eats her meals in her room and that the food is often cold by the time she gets it. Most of the time the food is cold by the time they bring it in to my room. The soup is never hot enough, sometimes I send it back, and they never return it, I think they forget about me." R147's admission MDS dated 12/17/14, indicated she had mild cognitive deficits. During interview	F 364	The facility updated the policy for utilizing the plate/pellet warmer on 3/18/15. The warming unit will be turned on 1/2 hour prior to meal service and will remain on throughout the meal service. Dietary staff will be educated on the proper use of the plate/pellet warmer by 3/27/15. Resident dietary interview forms have been updated to include specific questions regarding temperature, palatability, taste, appearance and satisfaction. They will also be asked about the variety of food offered. The interview forms will be completed after a resident is admitted and at least quarterly. A test tray system was developed on 2/27/15 to monitor the temperature of food being delivered on room carts. The Food Service Director conducts a test tray weekly and will document the results. Dietary interviews will be conducted with R7, R38, R147, R59 and R16 to update preferences and to inform them of the changes made in the dietary department. The results of the interviews and test trays will be presented at the next QAPI meeting in April 2015. The Food Service Director is responsible	3/27/15

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 _____	02/26/2015

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
F 364	Continued From page 24 on 2/23/15, at 7:08 p.m. R147 stated "the food is cold mainly during lunch and supper I think after they get the food ready and when it gets to me it is cold." R7's quarterly MDS dated 1/16/15, indicated she was cognitively intact. During interview 2/26/15, at 3:13 p.m. R7 stated "the food is terrible and by the time it gets to my room, its cold." R59's during interview 2/25/14, at 6:10 p.m. family member (F)- B stated I am her almost daily and when my mother receives her food it is usually cold she has to wait so long to get served especially in the evening." R38's during interview 2/26/15, at 10:30 a.m. family member (F)-A, stated "the food is cold I even have a hard time cutting it, it is just not as tasty I am her during lunch time." During observation of the noon meal 2/25/15, at 1:00 p.m. after the last tray was served in the main dining room the surveyor requested a sample test tray of the main dish served which consisted of chicken, rice and peas. The temperature of the test tray was immediately taken. The peas were 120 degrees Fahrenheit, were cold to taste. During interview 2/25/15, at 1:15 p.m. R16 stated "I didn't eat much today, my food was cold and if it is cold I just wont eat it." During interview 2/25/15, at 1:19 p.m. R124 stated while sitting in his room "I didn't eat my lunch today it was cold so I sent it back to the aide. I sure would like some warm bean soup."	F 364	to monitor for compliance.	

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F 364	Continued From page 25 During interview 2/25/15, at 1:22 p.m. nursing assistant (NA)-K stated R124 "did refuse his lunch and doesn't doubt it was cold by the time the hall trays get to his room it is cold." During interview 2/25/15, at 1:25 p.m. R147 stated her" peas at lunch today were cold." During interview 2/26/15, at 10:18 a.m. the dietary director stated "the peas should have been warmer than 120 degrees and I don't deny that is too cold." The facility undated policy of, Acceptable Food Service Temperatures identified the vegetables should be 140 degrees Fahrenheit but preferably 140-165 degrees F.	F 364		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		3/27/15

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F 431	Continued From page 26 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure Fentanyl patches (narcotic pain medication administered via a skin patch) were disposed of per facility policy for 1 of 1 residents (R84) in the sample who was prescribed a Fentanyl patch. Findings include: During medication storage review on 02/26/2015 at 8:56 a.m., licensed practical nurse (LPN)-A stated his practice of disposing Fentanyl patches were to toss them into the regular garbage. In addition, LPN-A stated he did not have a second, licensed staff witness the disposal. In an interview on 02/26/2015 at 9:10 a.m., trained medication aid (TMA)-F stated, "I fold it up [the resident's used Fentanyl patch] in a tissue and toss it in the toilet." TMA-F said she did not have anyone witness the process of destruction .	F 431	The facility updated its policy and procedure for Medication Destruction in consultation and agreement with our consulting pharmacist. The policy now includes, Fentanyl patches (used or unused)will be flushed down the toilet as documented and witnessed by two nurses. Licensed nurses will receive the updated policy by 3/27/15. The disposition will be documented on the Medication Disposition Form. The DON will review the form for compliance and will present the results at the next QAPI meeting in April 2015.	

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 _____	02/26/2015

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F 431	Continued From page 27 During an interview on 02/26/2015 at 9:15 a.m. with TMA-G stated, that she puts gloves on, places a tissue around the Fentanyl patch and flush it down the toilet. She confirmed that she does not have any witnesses observe the destruction. Review of the facility medical administration record (MAR) for February 2015, identified R84, was receiving Fentanyl patches for pain relief. In a telephone interview on 02/26/2015 at 10:37 a.m., the consultant pharmacist (CP) stated he was unaware of the facility policy for the destruction of Fentanyl patch, but Fentanyl patches should not be thrown into the regular garbage. During an interview on 02/26/2015 at 10:52 a.m. director of nursing (DON) stated the policy was always to have destruction of narcotics with two witnesses. I know the policy says we have to have two witnesses and expects them to flush the Fentanyl patches. She stated most medications are destroyed by pharmacy and nursing and we train the nurses to have two persons witness for destruction of narcotics. Review of the facility's undated policy and procedure entitles Medication Destruction Park River Estates Care Center identified the medication disposal and documentation must be done in the presence of two licensed nurses or one licensed nurse and a pharmacist.	F 431		

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	245448	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2015**

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PARK RIVER ESTATES CARE CENTER	**9899 AVOCET STREET NORTHWEST** **COON RAPIDS, MN 55433**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2015

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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	245448	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2015**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Park River Estates Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1988, an addition was constructed to the South Wing that was determined to be of Type II(111) construction. Another addition was added in 1992 to the East Wing and was determined to be of Type II(111). Because the original building and the 2 additions can be lowered to the lowest construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. 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 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a)is NOT MET as evidenced by:	K 000		

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K 017	Continued From page 2	K 017		
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has not maintained the corridors in accordance with NFPA 101 (2000 edition), Chapter 19, Section 19.3.6.1. This could affect the residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 02/27/2015, observation revealed that the corridor leading into the TCU building has penetrations above the ceiling that are not properly firestopped. This deficient practice was verified by the maintenance director at the time of the	K 017	The facility has properly firestopped the penetrations above the ceiling. This was completed by the maintenance director and assistant. The open penetrations were the result of prior contractors performing work above the ceiling tile. The facility will inform all contractors that if any penetrations are made to perform their work, it is the contractors responsibility to firestop the penetrations. The Director of Maintenance will inspect areas where work has been performed by all contractors to assure all penetrations are firestopped. Payment will not me made until the contractor complies with	3/27/15

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K 017	Continued From page 3 inspection.	K 017	this. Future inspection results will be presented at th Next QAPI meeting. The Director of Maintenance is responsible to monitor for compliance.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's kitchen cooking equipment has not been maintained in accordance with Sec. 9.2.3 and NFPA 10. This deficient practice could affect some residents if near the kitchen. Findings include: On facility tour between 9:30 AM and 11:30 AM on 02/27/2015, observation revealed that the grease filters in the commercial kitchen are mesh type and not baffle type. This deficient practice was verified by the maintenance director at the time of the inspection.	K 069	The Director of Maintenance has ordered and installed baffle type grease filters for the kitchen. This is the only commercial kitchen area in the facility. If replacements are needed in the future, the Director of Maintenance will be responsible for ordering and installing only baffle type filters. The purchase and installation of the baffle filters will be presented at the next QAPI meeting in April 2015.	3/27/15

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	245448	A. BUILDING **02 - NEW WING** B. WING _____	**02/27/2015**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This wing onto Park River Estates was constructed in 2011. It is a one story building with no basement. The construction type is determined to be type II(111). The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire doors. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 99 beds with a census of 91 at the time of inspection. The requirement at 42 CFR, Subpart 483.70(a)is NOT MET as evidenced by:	K 000		
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of	K 017		3/27/15

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K 017	Continued From page 2 smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the corridor walls which form a barrier to limit the transfer of smoke in accordance with NFPA 101, Section(s) 18.3.6.1, 18.3.6.2 and 18.3.6.5. This deficient practice could effect all residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 02/27/2015, observation revealed that the corridors within the TCU have penetrations above the ceiling that are not properly firestopped. This deficient practice was verified by the maintenance director at the time of the inspection.	K 017	The facility has properly firestopped the penetrations above the ceiling. This was completed by the maintenance director and assistant. The open penetrations were the result of prior contractors performing work above the ceiling tile. The facility will inform all contractors that if any penetrations are made to perform their work, it is the contractors responsibility to firestop the penetrations. The Director of Maintenance will inspect areas where work has been performed by all contractors to assure all penetrations are firestopped. Payment will not me made until the contractor complies with this. Future inspection results will be presented at th Next QAPI meeting. The Director of Maintenance is responsible to monitor for compliance.	