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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J69M

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 April 3, 2013 (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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE HEII 04/15/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 06/21/2013 (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 6/21/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/19/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

An abbreviated standard Opportunity to Correct survey was completed at this facility on December 18, 2012. The most serious deficiencies were found at a scope and severity (S/S) level of D.

A Post Certification Revisit (PCR) was completed on January 28, 2013. Two deficiencies were found uncorrected at a S/S level of D.

As a result, we recommended the following to CMS:

- Mandatory Denial of Payment for New Admissions (DOPNA) effective March 18, 2013.

An extended No Opportunity to Correct survey was completed on February 15, 2013. The most serious deficiency was cited at a S/S level of F. Also at the time of the survey, conditions were found in the facility that constituted Substandard Quality of Care to resident health or safety.

As a result this Department imposed State Monitoring effective March 11, 2013. In addition, we recommended to the CMS RO imposition of the following remedies:

- A Per Instance Civil Money Penalty (CMP) in the amount of $1,700.00 for the deficiency at F226 effective February 15, 2013 for a total amount of $1,700.00

- Mandatory DOPNA effective March 18, 2013 remains in effect.

A PCR was completed on April 3, 2013 of the abbreviated standard survey and the extended survey and all deficiencies were found corrected effective March 18, 2013. As a result of the revisit findings, State Monitoring was discontinued effective March 18, 2013. In addition, this Department is recommending the following:

- A Per Instance CMP in the amount of $1,700.00 for the deficiency at F226 effective February 15, 2013 for a total amount of $1,700.00 remain in effect

- Mandatory DOPNA effective March 18, 2013 is discontinued

This facility is also subject to Nursing Assistant Training Competency Evaluation Program (NATCEP) loss effective February 15, 2013 due to the extended survey.

Effective March 18, 2013, the facility is certified for 99 skilled nursing facility beds.

Please refer to the CMS 2567B.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5448 May 31, 2013

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 18, 2013, 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.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 15, 2013

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

RE: Project Number S5448020 & H5448026

Dear Mr. Pollock:

On March 6, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 11, 2013. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 18, 2013 would remain in effect. (42 CFR 488.417 (b))

- Per instance civil money penalty of $1,700.00 for the deficiency cited at F226, effective February 15, 2013, for a total penalty of $1,700.00 would remain in effect. (42 CFR 488.430 through 488.444)

Also, this Department notified you in our letter of March 6, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 15, 2013.

This was based on the deficiencies cited by the Office of Health Facility Complaints for an abbreviated standard survey completed on December 18, 2012, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on January 28, 2013. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 15, 2013, the Minnesota Departments of Health and Public Safety completed an extended survey 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 to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required.

On April 3, 2013, the Minnesota Department of Health and on March 27, 2013 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 the abbreviated standard survey completed on December 18, 2012, the PCR completed on January 28, 2013 and the extended survey completed on February 15, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated

standard survey completed on December 18, 2012, the PCR, completed on January 28, 2013 and the extended survey completed on February 15, 2013. As a result of the revisit findings, this Department is discontinuing the Category 1 remedy of state monitoring effective March 18, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies:

- Per instance civil money penalty of $1,700.00 for the deficiency cited at F226, effective February 15, 2013, for a total penalty of $1,700.00 would remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 18, 2013 would be discontinued. (42 CFR 488.417 (b))

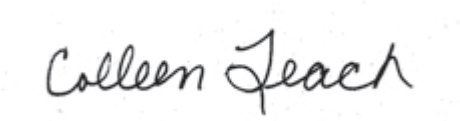
As we notified you in our letter of March 6, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 15, 2013.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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	4/3/2013

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/18/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/18/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/18/2013**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **03/18/2013**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **03/18/2013**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **03/18/2013**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/18/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/18/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/18/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/18/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/18/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/18/2013**
ID Prefix **F0469** Reg. # **483.70(h)(4)** LSC	Correction Completed **03/18/2013**	ID Prefix **F0496** Reg. # **483.75(e)(5)-(7)** LSC	Correction Completed **03/18/2013**	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/cbl	04/15/2013	31223	04/03/2013
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
2/15/2013			

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 A. Building B. Wing	(Y3) Date of Revisit
245448	01 - MAIN BUILDING 01	3/27/2013

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 K0144	03/11/2013	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 State Agency	**Reviewed By** PS/cbl	**Date:** 04/15/2013	**Signature of Surveyor:** 03005	**Date:** 03/27/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/12/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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 02 - NEW WING	3/27/2013

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 Reg. # NFPA 101 LSC K0144	Correction Completed 03/11/2013	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	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 State Agency	Reviewed By PS/cbl	Date: 04/15/2013	Signature of Surveyor: 03005	Date: 03/27/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/12/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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	4/3/2013

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**03/18/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**03/18/2013**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KL/cbl	04/15/2013	31223	04/03/2013
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
12/18/2012	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J69M

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 **02/15/2013** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NEII 03/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/19/2013 (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 4/19/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

An abbreviated standard Opportunity to Correct (OTC) survey was completed at this facility on December 18, 2012. The most serious deficiencies were found at a scope and severity (S/S) level of D.

A Post Certification Visit was completed on January 28, 2013. Two deficiencies were found uncorrected at a S/S level of D.

As a result, this Department recommended the following to CMS:

- Mandatory Denial of Payment for New Admissions (DOPNA) effective March 18, 2013.

An extended No Opportunity to Correct (NOTC) survey was completed on February 15, 2013. The most serious deficiency was cited at a S/S level of F. Also at the time of the survey, conditions were found in the facility that constituted Substandard Quality of Care (SQC) to resident health or safety.

As a result this Department imposed State Monitoring effective March 11, 2013. In addition, we recommended to the CMS RO imposition of the following remedies:

- A Per Instance (CMP) Civil Money Penalty in the amount of $1,700.00 for the deficiency at F226 effective February 15, 2013 for a total amount of $1,700.00

- Mandatory DOPNA effective March 18, 2013 remains in effect.

This facility is also subject to Nursing Assistant Training Competency Evaluation Program (NATCEP) loss effective February 15, 2013 due to the extended survey.

Post certification revisit to follow. Please refer to the Statement of Deficiencies (CMS 2567) along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9714

March 6, 2013

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

RE: Project Number S5448020 & H5448026

Dear Mr. Pollock:

On February 5, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 18, 2013. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on December 18, 2012, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on January 28, 2013. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 15, 2013, the Minnesota Departments of Health and Public Safety completed a standard survey 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 to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required.

As a result of the February 15, 2013 survey findings that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective March 11, 2013. (42 CFR 488.422)

Additionally, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Per instance civil money penalty of $1,700.00 for the deficiency cited at F226, effective February 15, 2013, for a total penalty of $1,700.00. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 18, 2013 would remain in effect. (42 CFR 488.417 (b))

Please note that due to the February 15, 2013 extended survey, your facility is also prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 15, 2013.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Park River Estates Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective February 15, 2013. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding Department waivers for these programs.

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
Minnesota Department of Health
Midtown Square
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (218) 302-6151

Fax: (218) 723-2359

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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

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 June 18, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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.

Feel free to contact me if you have questions.

Sincerely,

Brenda Fischer

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7338 Fax: (320) 223-7348

Enclosure

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 _____	02/15/2013

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. 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 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	**This Plan of correction is being submitted pursuant to the applicable federal & state regulations. Nothing contained herein shall be construed as an admission that the facility violated any federal or state regulation or failed to follow any applicable standard of care. The facility believes they were in substantial compliance with the federal tag listed below.**	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	**F 225** The facility has policies and procedures that ensure all alleged violations involving abuse are immediately reported to the administrator, director of nursing and OHFC ~~in accordance with the law~~ in order to prevent further potential abuse of a resident. The facility will report immediately to the web based OHFC system regarding allegations violations of abuse. The transfer was not "smooth" because the nursing assistant transferred R120 by herself and without a transfer belt. This is against our policy which this one nursing assistant did not follow. Regarding R120, the nursing assistant did receive corrective action stating that one more incident of this level will result in suspension subject to termination. Regarding R45, R73 and	3/18/13 3/20/13 ok. per Tom Pollock-Hoty BT

3/20/13 accepted BT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 3/11/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bruises of unknown origin were immediately reported to the state agency for 3 of 3 residents (R45, R73 & 201) reviewed with injuries of unknown origin. In addition, the facility failed to ensure a resident allegation of neglect was investigated and reported to the state agency and administrator for 1 of 1 resident, (R120), who reported staff neglect. Findings include: R45 was noted to have a bruise on his left foot and was noted to be an injury of unknown origin which was not immediately reported to the state agency. R45 had diagnosis including cerebral vascular accident and long term use of aspirin. The quarterly minimum data set (MDS) dated 1/4/13 indicated he was cognitively impaired and needed extensive assist of two with transfers.	F 225	R201, the Administrator and DON were notified immediately and OHFC online report was not done immediately. The investigations were completed and submitted to OHFC within the time required. The RN's & LPN's have been educated to immediately contact the Administrator and DON and to make the report online to OHFC. Instructions for online reporting are provided by the designated computers. All residents could be affected by not reporting "immediately". The policies and procedures are communicated to all employees upon hire and at a minimum annually. The policies and procedures are also available at each nursing station. The Resident Incident Report has also been updated to include date and time when the Administrator, DON, and state agencies are notified. The facility will continue its practice of reviewing incident reports at the stand up meeting for alleged abuse and if immediate notifications were reported according to the facility's policy and procedure. The charge nurse will review incident reports on off hours to assure proper notification and will initial them. Reports of alleged abuse, injuries of unknown origin, and calls made to the Administrator, DON, and OHFC will be reviewed by the Quality Assessment and	

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F 225	Continued From page 2 R45's current plan of care dated 10/23/12 indicated staff to evaluate/assess and to monitor for skin breakdown, thrombus formation and report. Review of the facilities incident reports indicated that on 2/7/13 , R45 was noted to have a bruise on his left foot, across the top, over the toes, and around the outer ankle. The report further indicated he was unable to answer questions of how it happened and is unknown as to origin of injury. The bruise measured 8 centimeters (cm) by 8 (cm). There was no indication the state agency was immediately notified of the injury. During interview on 2/14/13 at 8:30 a.m., with the Director Of Nursing (DON) stated the injury was noted to R45 on 2/7/13 at 2:00 p.m and that it was not reported to the state agency until 2/8/13 at 10:00 a.m. Although the facility was aware of R45's injury of unknown origin the facility did not notify the state agency immediately. R73 was noted to have a bruise of unknown origin to her left outer arm which was not immediately reported to the state agency. R73 had diagnoses including dementia and osteoarthrosis. The quarterly minimum data set (MDS) dated 11/23/12 identified the resident to be cognitively impaired and was an extensive two person assist with all transfers. R73's current plan of care dated 1/30/13 instructed staff the resident required hoyer lift	F 225	Performance Improvement committee. The Director of Staff Development will monitor to assure all staff are communicated the policies and procedures upon hire and at least annually.	

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F 225	Continued From page 3 transfers. Review of the facility incident report dated 2/13/13 indicated the staff found a bruise of unknown origin to her left outer arm at 6:30 a.m. during am cares which measured 8 cm by 7 cm. The facility notified the state agency 2/13/13 at 7:30 p.m., 13 hours after the incident occurred. There was no indication the state agency was immediately notified of the injury. During interview on 2/14/13 with the DON stated she did not notify the state agency until later in the evening because she was busy. Although the facility was aware of R73's injury of unknown origin to her left arm the facility failed to notify the state agency immediately. R201 was noted to have a bruise of unknown origin to her right inner ankle which was not immediately reported to the state agency. R201 had diagnoses of cerebral vascular accident and confusion. The admission (MDS) dated 1/28/13 indicated R201 is cognitively impaired and needs extensive assistance with transfers. Review of the facility incident report dated 2/14/13 indicated that at 12:30 a.m., R201 was noted to have a bruise on unknown origin on her right inner ankle measuring 2 cm by 3cm. The incident report further stated that the resident reported it to the staff but was unable to specify what happened. The state agency was not notified until 2/14/13 at 10:00 a.m., 9 1/2 hours	F 225		

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F 225	Continued From page 4 after the incident occurred. Although the facility was aware of R201's injury of unknown origin to her right inner ankle the facility failed to notify the state agency immediately. During interview on 2/13/13 at 1:20 p.m., the DON stated with all of the incidents the staff called the administrator and they also call Vulnerable Adults. The DON further stated she was not aware that the state agency needed to be notified immediately and had up to 24 hours to notify the state agency. During interview on 2/14/13 at 10:30 a.m., with the Administrator stated that he is called immediately with any injuries of unknown origin and then the staff also immediately call vulnerable adults. The administrator further stated that the DON then notifies the state agency with in 24 hours. R120 reported a staff member was "rough" with her and did not transfer her according to the plan of care. This was not immediately reported to the administrator or state agency. R120 had diagnoses including pain and high risk for falls. The quarterly minimum data set (MDS) dated 1/24/13 identified the resident had no cognitive impairment and was an extensive two person assist with all transfers. R120's current plan of care dated 1/29/13 instructed staff the resident required transfer	F 225		

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F 225	Continued From page 5 assist of two staff with use of a transfer belt. During interview on 2/11/13 at 3:11 p.m. R120 stated "about a week ago or so" a nursing assistant (NA) was rough with her while transferring her onto the toilet. The resident stated the NA transferred her alone and did not use a transfer belt which made for a rough transfer and it "scared" the resident because she had fallen in the past. R120 stated she had reported the incident to the social worker. During interview on 2/13/13 at 9:40 a.m. social worker (SW)-A stated R120 had told her a NA being rough with her and did not transfer her according to the plan of care. SW-A stated she reported the incident to the director of nursing (DON) and was unsure what happened. She had not followed up with R120 or the DON about the incident. During interview on 2/14/13 at 11:00 a.m. DON stated R120 had reported NA-C had transferred her without a transfer belt and did not have a second person assisting. DON stated R120 told her it "scared" her and was "rough." DON provided an Employee Corrective Action Record for NA-C dated 2/5/13 which indicated she did not "use a transfer belt" on R120 and did not use a "two person transfer and didn't do night time peri-care" on the resident. This was not signed by NA-C until 2/13/13, 8 days after the incident was reported to the DON. DON stated she had not been able to "catch up with" NA-C to talk to her about the incident. DON stated this was not reported to the state agency or the administrator as it was being dealt with by the facility. DON also verified there was no monitoring being done	F 225		

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F 225	Continued From page 6 for NA-C to ensure residents cares are being followed. DON was unable to provide any investigation of the incident with R120. During interview on 2/14/13 at 11:30 a.m. the administrator stated he was not aware of the incident with R120 and NA-C. Although the facility was aware R120's plan of care was not followed to ensure safety and the resident felt she was treated roughly, this was not investigated or immediately reported to the state agency or administrator.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident report of staff neglect for 1 of 1 resident, R120, was thoroughly investigated and immediately reported to the administrator and state agency. Also, the facility to did not ensure bruises of unknown origin were immediately reported to the state agency as directed by the facility policy for 3 of 3 residents (R73, R45 and R201) who had injuries of unknown origin. This had the potential to effect all 94 residents who currently resided in the facility.	F 226	F226 Refer to F225 for detailed plan of correction.	3/18/13

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F 226	Continued From page 7 Findings include: The facility policy and procedure titled Abuse Prevention Plan for Vulnerable Adults dated 4/2012 identified "All prospective employees will be screened with interviews... verification of current licensure or certification... The director of nursing (DON) and the administrator will review all resident incident reports for indication of abuse/ neglect... If a determination was made that abuse or neglect occurred; documentation must include: Clinical findings, determine causative factors, initial reporting process, protection process, investigation process, process for reporting results of the incident to state and federal officials, collaboration with state agencies as appropriate..." The facility policy titled Abuse and Neglect Prevention/ Federal Reporting dated 4/2012 indicated "In accordance with federal requirements, the following definition delineate what is to be reported to the administrator, DON, and MDH (Minnesota department of health) immediately, meaning as soon as possible, but not more than 24 hours after the discovery of the incident." During interview on 2/13/13 at 1:20 p.m. DON stated the facility nurses are trained to call the common entry point (CEP) if they suspect abuse, however, only the assistant director of nursing (ADON) and herself are able to submit reports to the state agency. She stated the nurses call her and the administrator at home "immediately" if they suspect resident abuse, however, the DON has 24 hours to submit a report to the state	F 226		

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F 226	Continued From page 8 agency. DON stated if she gets a call in the evening about suspected resident neglect, she would wait until the next day to file a report with the state agency as she has 24 hours to submit. During interview on 2/13/13 at 3:00 p.m. registered nurse (RN)-A stated if suspected abuse or neglect occurred, she would contact the administrator and DON at home immediately and call CEP to report the incident. However, she stated she had not been trained and did not have access to submit any reports to the state agency. RN-A also stated she was not aware of any staff member accused of neglect of health care and was never told to do any extra monitoring on any staff member. When interviewed on 2/13/13 at 3:25 p.m., assistant director of nursing (ADON) stated, "if the DON has too much on her plate, I will go online and report incidences to the state agency, we have 24 hours to report after the incident occurred." During interview on 2/14/13 at 11:30 a.m. the administrator stated the facility policy was they had 24 hours to report to the state agency any neglect, bruises of unknown origin, or suspected resident abuse. R120 reported a staff member was "rough" with her and did not transfer her according to the plan of care which was not immediately reported to the administrator or state agency immediately as directed by the facility policy. R120 had diagnoses including pain and high risk	F 226		

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for falls. The quarterly minimum data set (MDS) dated 1/24/13 identified the resident had no cognitive impairment and was an extensive two person assist with all transfers.

R120's current plan of care dated 1/29/13 instructed staff the resident required transfer assist with two staff and use of a transfer belt.

During interview on 2/11/13 at 3:11 p.m. R120 stated "about a week ago" a nursing assistant (NA) was rough with her while transferring her onto the toilet. The resident stated the NA transferred her alone and did not use a transfer belt which made for a rough transfer and it "scared" the resident because she had fallen in the past. R120 stated she had reported this to the social worker.

During interview on 2/13/13 at 9:40 a.m. social worker (SW)-A stated R120 had told her something about this incident but she reported it the director of nursing (DON) to take care of. She was unsure what happened as she had not followed up with R120 or the DON about the incident.

During interview on 2/14/13 at 11:00 a.m. DON stated R120 had reported NA-C had transferred her without a transfer belt and did not have a second person assisting. DON stated R120 told her it "scared" her and was rough. DON provided a Employee Corrective Action Record for NA-C dated 2/5/13 which indicated she did not "use a transfer belt" on R120 and did not use a "two person transfer and didn't do night time peri-care" on the resident. This was not signed by NA-C until 2/13/13, 8 days after the incident was

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F 226	Continued From page 10 reported to the DON. DON stated this was not reported to the state agency, CEP, or the administrator. DON also verified there was no monitoring being done for NA-C to ensure residents cares are being followed. DON was unable to provide any investigation or incident report of the incident with R120 with NA-C according to facility policy. During interview on 2/14/13 at 11:30 a.m. the administrator stated the incident with R120 had not been reported to him. R45 was noted to have a bruise on his left foot and was noted to be an injury of unknown origin which was not immediately reported to the state agency. R45 had diagnoses including cerebral vascular accident and long term use of aspirin. The quarterly minimum data set (MDS) dated 1/4/13 indicated he was cognitively impaired and needed extensive assist of two with transfers. R45's current plan of care dated 10/23/12 indicated staff to evaluate/assess and to monitor for skin breakdown, thrombus formation and report. Review of the facilities incident reports indicated that on 2/7/13 at , R45 was noted to have a bruise on his left foot, across the top, over the toes, and around the outer ankle. The report further indicated he was unable to answer questions of how it happened and is unknown as to origin of injury. The bruise measures 8 centimeters (cm) by 8 (cm).	F 226		

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F 226	Continued From page 11 During interview on 2/14/13 at 8:30 a.m., with the Director Of Nursing (DON) stated the injury was noted to R45 on 2/7/13 at 2:00 p.m and that it was not reported to the state agency until 2/8/13 at 10:00 a.m. Although the facility was aware of R45's injury of unknown origin the facility did not notify the state agency immediately. R73 was noted to have a bruise of unknown origin to her left outer arm and was not immediately reported to the state agency. R73 had diagnoses including dementia and osteoarthrosis. The quarterly minimum data set (MDS) dated 11/23/12 identified the resident had to be cognitively impaired and was an extensive two person assist with all transfers. R73's current plan of care dated 1/30/13 instructed staff the resident required hoyer lift transfers. Review of the facility incident report dated 2/13/13 indicated the staff found a bruise of unknown origin to her left outer arm at 6:30 a.m. during am cares which measured 8 cm by 7 cm. The facility notified the state agency 2/13/13 at 7:30 p.m. During interview on 2/14/13 with the DON stated she did not notify the state agency until later in the evening because she was busy. Although the facility was aware of R73's injury of unknown origin to her left arm the facility failed to	F 226		

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F 226	Continued From page 12 notify the state agency immediately. R201 was noted to have a bruise of unknown origin to her right inner ankle that was not immediately reported to the state agency. R201 had diagnoses of cerebral vascular accident and confusion. The admission (MDS) dated 1/28/13 indicated R201 is cognitively impaired and needs extensive assistance with transfers. Review of the facility incident report dated 2/14/13 indicated that at 12:30 a.m., R201 was noted to have a bruise on unknown origin on her right inner ankle measuring 2 cm by 3cm. The incident report further stated that the resident reported it to the staff but was unable to specify what happened. The state agency was not notified until 2/14/13 at 10:00 a.m. Although the facility was aware of R201's injury of unknown origin to her right inner ankle the facility failed to notify the state agency immediately. During interview on 2/13/13 at 1:20 p.m., the DON stated that with all of the incidents the staff call her the administrator and they also call Vulnerable Adults. The DON further stated she was not aware that the state agency needed to be notified immediately. During interview on 2/14/13 at 10:30 a.m., with the Administrator stated that he is called immediately with any injuries of unknown origin and then the staff immediately call vulnerable adult. The administrator further stated that the	F 226		

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F 226	Continued From page 13 DON then notifies the state agency with in 24 hours. The administrator then stated he was not aware the state agency needs to be notified immediately.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 17 residents (R14), who ate in the enhanced dining room, was provided a dignified dining experience, while staff stood over the resident to assist with eating. Findings include: R14's diagnosis included Alzheimer's dementia. The quarterly minimum data set (MDS) dated 11/14/12, indicated severe cognitive deficits, and required total staff assistance to eat. R14 ' s care plan dated 2/3/11, included, "Total assist with all food/fluid intake." R14's care plan dated 2/3/11, indicated R14 had an alteration in communication and directed staff to gain his attention by talking to him face to face. The care plan also indicated R14 required total staff assistance for eating. R14 was observed being fed his evening meal by	F 241	**F 241** The facility does promote care for our residents that maintain their dignity and respect in full recognition of his or her individuality. All nursing staff have been reminded to sit down as the proper manner on how to provide for a resident requiring total assistance for eating. The one LPN has been re-educated on the proper way to provide for a resident requiring total assistance for eating including R14. The Director of Staff Development will monitor to assure that all staff is educated upon hire and annually on dignity and respect for the individual resident. The DON or her designee will monitor the enhanced dining room at least once per week for the next four weeks during varied meals and the results will be reported to the Quality Improvement Committee. The DON is responsible to monitor.	3/18/13

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F 241	Continued From page 14 licensed practical nurse (LPN)-B, in the enhanced dining room, 2/11/13 from 5:40 p.m. until 6:05 p.m. During this time LPN-B stood over R14 while feeding him. During the observation LPN-B also left R14 to assist other residents, and then returned to R14 to assist him to eat, then left again to assist another resident. LPN-B continued to do this, in this manner, four times during the evening meal. When R14 was not being assisted, he sat and made no attempts to fed himself. At 6:05 p.m. a nurse aid came and sat down and assisted R14 with the remainder of his meal. When interviewed on 2/14/13 at 1:15 p.m. the director of nursing (DON) stated she had noticed LPN-B standing over R14 when she was feeding him on 2/11/13, and had directed the assistant director of nursing to inform LPN-B that she should sit down to feed residents. The ADON had done so, but LPN-B remained standing to feed residents. A facility policy was requested, but not provided.	F 241		
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:	F 242	**F 242** The facility does allow residents to make choices. Bathing preferences for R103 & R120 was discussed with them and will be reviewed at least quarterly at their care conference. All residents have been asked if their preferences are correct or desire to have them changed and then reviewed at their quarterly care conferences. The director of social services will be responsible for confirming choices at the quarterly care conferences and communicate them to the appropriate department.	3/18/13

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F 242	Continued From page 15 Based on observation, interview and document review, the facility failed to ensure 2 of 2 resident reviewed; R103 & R120, was provided bathing preferences according to previous life routines. In addition, the facility failed to ensure 1 of 1 residents (R48) was provided with meal choices. Findings include: R103 voiced a preference to take a shower, rather than a tub bath, and preferred the shower in the morning. R103 was provided a tub bath in the evening instead. R103's diagnosis included fall with hip fracture and dementia. The admission minimum data set (MDS) dated 12/24/12, included moderate cognitive impairment, and required physical assistance with bathing. The MDS further indicated it was somewhat important for R103 to choose between a tub bath or a shower. R103's care plan dated 12/28/12, directed staff to assist with bathing and "allow resident to maintain some control over life by making decisions about what to eat, what to wear, when to rest, etc." R103 was interviewed on 2/11/13 at 2:30 p.m., she stated when she was admitted in December 2012, she was told she was assigned to receive a bath once a week on Wednesday evenings. R103 stated she would prefer to take a shower in the morning, rather than a tub bath in the evening, and had voiced this preference to a couple nurse aids. The nurse aids told her the assignment could not be changed. Therefore, R103 did not mention it to any staff again, but stated it really bothers her that she is unable to make this	F 242	The facility does provide residents with meal choices. The facility was in error to "Cooks to meet with the resident every day to see what she would like for the day" as it would be very difficult for the cook to meet with every resident every day. The assistant dietary manager did meet with resident R48 and reviewed the weekly menu with her preferences noted on the menu. The facility also offers at least an alternate to the main meal being served. All residents have been asked if they receive the food they want and if they receive food that they don't want. The dietary aides will ask the residents if their preferences are being honored. The Assistant Dietary Manager will be responsible to make sure resident preferences are noted on their diet slip. This will also be reviewed at least quarterly at the resident's care conference. The Assistant Dietary Manager will provide information on resident preference success at the next Quality Improvement meeting.	3/18/13

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F 242	Continued From page 16 choice. When interviewed on 2/15/12 at 10:45 a.m., social service worker (SS)-B, stated she interviews residents about their preferences when completing the MDS, but nursing assigns the bathing schedule. Preferences are not communicated other than the documentation on the MDS. Even though staff were aware R103 found it important to choose what type of bathing activity she received, and she voiced a preference, the facility failed to allow her this option. R120 quarterly minimum data set (MDS) dated 1/24/13 identified the resident had no cognitive impairment and was an extensive two person assist with all activities of daily living (ADL's). During interview on 2/11/13 at 3:10 p.m. R120 stated when she was admitted to the facility they told her she gets one bath a week and told her which day that would be. R120 stated she would like "at least two baths a week" but was not given a choice about bathing and stated one bath a week is "a rule here," so she did not bother asking anyone. She stated before being admitted to the facility she took a bath or shower daily. During interview on 2/13/13 at 9:40 a.m., social worker (SW)-A stated when residents are admitted social work does not address previous life routines with the resident as that is not part of their admission process. During interview on 2/13/13 at 9:50 a.m. the director of nursing (DON) stated when residents	F 242		

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F 242	Continued From page 17 are admitted to the facility they are not asked about previous life routines with bathing. She stated every resident is assigned a bath time once a week, however, if a resident would ask they would try to work in another bath for them during the week. During interview on 2/15/13 at 8:55 a.m. registered nurse (RN)-A stated when residents are admitted they are assigned a bath day once a week, however, they do not ask the resident if they would like anything different. During interview on 2/15/13 at 9:10 a.m. nursing assistant (NA)-D stated every resident had an assigned day for a shower once a week. She stated it is very difficult to change the day or add an extra one as that is what they are assigned when they are admitted to the facility. No further information was provided. R48 was not given a choice of meal preferences on a daily basis. R48's diagnoses include adult failure to thrive, heart failure and Barrettes esophagus. R48's quarterly (MDS) dated 12/7/12 indicated she is cognitively intact and requires assistance of two staff for all activities of daily living (ADL ' s). R48's care plan dated 7/17/2012 indicated staff to meet with resident before each meal. Allow resident to make choices about what to eat. A dietary note dated 12/4/12 indicated " Receives pudding at breakfast Jello at lunch and supper. Cooks meet with resident every day to see what she would like for the day. "	F 242		

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F 242	Continued From page 18 R48's signed physicians orders dated 2/13/13 indicated resident diet order was a 2 gm (gram) sodium restricted. May have salt upon request. During observation on 2/13/13 at 10:49 a.m., R48 was sitting in her room she had cheerios on her table and Shasta pop. During interview on 2/13/13 at 10:50 a.m. with R48, stated the kitchen staff used to come in before every meal and ask me what I want, but they don't that anymore. Once in a great while they will come in, but not very often. They just bring me a tray and most of the time I can't eat it because it's too salty or too spicy. They have so many people, they can't just cook for me. R48 then stated I only get toast and cereal for breakfast. During interview with on 2/13/13 at 2:09 p.m., R48, stated that dietary did not come and ask what I wanted before lunch today. During interview on 2/13/13 at 2:13 p.m. the dietary manager (DM)-H stated dietary checks with R48 once a day to see what she wants to eat. She is afraid to eat a lot of foods, especially spicy foods. We have offered her basic things like bacon and soup and she won't even eat that. During observation on 2/14/13 at 9:03 a.m., R48 was sitting in her room, eating hot cereal and toast. During interview on 2/14/13 at 9:20 a.m. with DM-H, stated we let our cook go last Thursday and cook-A replaced her. The other cook didn ' t '	F 242		

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F 242	Continued From page 19 t tell cook-A to check with R48 every day to see what she wants. We don' t write it down anywhere for the kitchen staff to ask her what she wants, we just tell them to ask her. Cook-A asked R48 one time since she started last week and didn't know she was supposed to ask her every day. We serve her the usual stuff she likes. We used to do a weekly menu with her, but she got tired of it. During interview with on 2/14/13 at 9:34 a.m. with cook-A, stated the other cook that I replaced never told me I had to ask R48 what she wanted to eat every day, I think we're supposed to ask her. I didn ' t' t ask her today, I was too busy training in another person. I asked her what she wanted for lunch yesterday. I don 't offer the 2 gm meal because it's bland, I feel bad for them. During interview on 2/14/13 at 3:23 p.m. with R48 stated dietary did not come in today to ask what I wanted to eat, they just brought me steak and I asked them to take it away because my stomach was upset. No further information provided.	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 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 250		

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F 250	Continued From page 20 Based on interview and document review, social services failed to establish and maintain relationships with families in order to support residents' individualized psychosocial needs for 1 of 1 residents (R108) reviewed for social services. Findings include: R108's diagnosis included a stroke with hemiplegia (paralyzed on one side), and depression. R108 was enrolled in hospice for end of life cares. The significant change minimum data set (MDS) dated 1/3/13, indicated moderate cognitive impairment, required extensive to total assistance with all activities of daily living (ADL's), received an antidepressant medication, and life expectancy was less than 6 months. The Psychotropic drug use care area assessment (CAA) dated 1/3/13 included: "Resident is at risk for depression symptoms D/T {due to} his decline and is now on hospice." R108 was interviewed on 2/12/13 at 9:20 a.m., he stated he is unable to have visitors at any time he would like. R108 stated he likes his daughter to come and help him with personal cares, in the morning, but staff will not let her come in until later. R108 stated he was dying, and it was very important for him to have his family involved in his personal cares, and to be available to assist him with things he did not wish to bother staff with, such as getting warm towels for his legs, repositioning more frequent than staff offer, among other various things that make him more comfortable. During interview with R108's family member (FM) -K on 2/12/13 at 9:30 a.m., she stated she use to come in to visit about 7:00 a.m. to 7:30 a.m., but social services (SW)-B had asked her not to come in that early in the morning as it bothered	F 250	F 250 The facility does provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. The facility does encourage communication and avenues when concerns are not being addressed. The Resident Guide states that "Your thoughts, suggestions and concerns are always welcomed". The guide also has a Grievance Procedure that states"Residents are encouraged to voice concerns and suggestions to the Administrator..." Resident R108, FM-K, and FM-J have not voiced any concerns to the Administrator. The Director of Social Services and Director of Nursing will meet with R108, FM-K, and FM-J to discuss what is important to the resident, visits by the family anytime, hospice services, and expectations what is allowed or not. Staff use electric razors for the safety of the resident. The care plan for R108 will be updated to reflect the results of the meeting. All residents on hospice had their care plan reviewed. These will also be done at least quarterly and updated according to their preferences The Director of Social Service is responsible to monitor monthly and maintain compliance. A summary of the meeting will be presented to the Quality Improvement Committee at their next meeting.	3/18/13

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	245448	A. BUILDING _____ B. WING _____	02/15/2013

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F 250	Continued From page 21 the nurses. She would have go to the back door where staff enter the building and ring a bell to be allowed in. In addition, she had been told not to perform personal cares for her family member, as this was "staff's job." During interview with FM-J on 2/14/13 at 2:00 p.m. she stated SW-B had called her into the office to insist FM-K, as well as herself, not to assist R108 with washing up in the morning, boosting him up in bed, or assisting to get up or lay down. FM-J stated she had been told, "It is time for you two to just be a wife and a daughter, and allow staff to care for him." FM-K stated the front door to the facility is locked between 8:30 p.m. and 8:00 a.m., and she had been asked not to come outside of those hours, as it bothers the nursing staff when they have to stop what they are doing to let her in. FM-J stated she had tried to comply with the facilities wishes because she was afraid if she did not, staff could take it out on R108. In addition, FM-J stated it is very important for her to be part of caring for R108 while he was dying, and it is also important to R108. At 2:20 p.m. FM-K stated she does still do some personal cares for R108, but it is unclear what expectations the staff have as to what is allowed or not. During interview with R108 and FM-K on 2/15/13 at 8:49 a.m. FM-K stated she had shaved R108 with a regular shaver, not an electric one, as R108 enjoys this, as it is a much closer shave than the electric razor. Staff will only use the electric one. R108 stated he needs this done from time to time for comfort. FM-K stated staff had come in and told her she should not shave R108. But they are not willing to use a regular shaver. R108's care plan dated 12/31/12 included,	F 250		

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F 250	Continued From page 22 "Alteration in mood/behavior R/T {related to}: CVA {stroke} depression." Directions to staff included, "Allow resident to maintain some control over life by making decisions about what to eat, what to wear, when to rest, etc." The care plan did not direct to what extent family was allowed or disallowed to assist resident with cares or to visit him, nor the importance to R108 family involvement was. R108's nurse aid worksheet did not include any information on what types of care family was allowed to provide or any restrictions on visiting hours. During interview with SW-B on 2/14/13 at 3:26 p.m., she stated if family members need to come when the front door is locked, they may go around to the back of the building and ring a bell. She stated R108's family had been asked not to come in early in the morning, as the nurse aides are uncomfortable with family present. "I told them we will take care of his needs, it is time for them to be a wife and a daughter and not a care giver." SW-B stated family does assist R108 with some cares, but was unclear on what those cares are. Family should not assist with getting R108 in and out of bed, or boosting him up in bed, as this could be a liability to the facility. SW-B had not asked R108, or his family, if it was important to them to be involved in his personal cares. SW-B had not directed staff, in the care plan, as to what personal cares family may or may not provide, nor indicate any restrictions on visiting hours. SW-B provided a Resident Guide and identified this guide is provided to residents upon admission. On the back of the guide is a section entitled Visiting Information. This included, "The families of critically ill residents are welcome to visit at any time."	F 250		

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F 250	Continued From page 23 During interview with the director of nursing (DON) on 2/15/13 at 9:45 a.m., she stated she had instructed family to come to her with any concerns. DON was aware family assists R108 with cares a lot, but did not know what these cares were. DON stated family had been allowed to assist R108 with cares in a previous facility. They had placed restrictions on family members helping with transfers with the mechanical lift. "Washing him up is our job, if family wants to be a part of other things, that's ok. If they would come to me, I would add it to the care plan." A facility policy entitled Social Services, dated 2/5/13 included under number 3: "Strengthening communications among residents, families, and facility staff." Under number 6: "Acts as an advocate to all resident and their families to ensure the needs of all parties are met, while maintaining adherence to all State and Federal regulations." Even though the facility identified R108 had a terminal illness, R108 and his family expressed it was very important to him, and his family, to be involved with his personal cares, the facility placed unclear restrictions on that care, social services and nursing staff discouraged family members from providing personal care, and placed limitations on when they could visit.	F 250		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change	F 274		

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F 274	Continued From page 24 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT Is not met as evidenced by: Based on document review and interview, the facility failed to reassess 1 of 1 resident (R56), needs who had a significant change in physical needs which required a revision to the minimum data set (MDS). Findings included: R56's diagnosis included dementia. The quarterly minimum data set (MDS) dated 9/6/12, indicated R56 was independent for bed mobility, transfers, ambulation in room, locomotion, and toileting. R56 required supervision or oversight for ambulating in the corridor, dressing and hygiene. The next quarterly MDS dated 11/29/12, indicated R56 had declined to where she required extensive assistance with bed mobility, transfers, locomotion off unit, dressing, toileting and hygiene. In addition R56 did not ambulate during the assessment period. A significant change MDS was not completed even though there was a decline in these areas. R56's physician progress note dated 11/19/12, indicated R56 had fallen, and had been hospitalized with a pelvic fracture on 11/14/12,	F 274	**F 274** The facility does assess residents for a significant change. The facility was aware of R56's status as evidenced by the revised quarterly MDS assessment dated 11/29/12 that did indicate the decline. A Significant Change MDS should have been done instead of the quarterly MDS by the MDS Coordinator. The MDS Coordinator has been re-educated on when to complete a significant change MDS. The facility does conduct a weekly "Medicare Meeting" that covers those patients/residents requiring a Medicare covered service. The facility will also include any residents that have been determined to have had a significant change in their physical or mental condition during the past week and will conduct a comprehensive assessment when appropriate. A summary of those residents who had a significant change will be reviewed at the quarterly Quality Improvement Meeting. The Director of Nursing and MDS Coordinator are responsible for monitoring weekly and maintaining compliance.	3/18/13

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F 274	Continued From page 25 returning to the facility on 11/15/12 with orders for occupational therapy (OT), and physical therapy (PT), as well as pain management. R56's OT-Assistant Progress Update dated 12/11/12, indicated R56 continued to require assist of 2 nursing staff for toileting and continue to require assistance with ambulation. This was 27 days after initial change in condition (fall resulting in pelvic fracture on 11/14/12). R56's PT Plan of Care notes dated 12/14/13, indicated R56 required maximum staff assistance for transfers and bed mobility. This was 30 days after initial change in condition. When interviewed on 2/15/12 at 10:00 a.m. the MDS nurse (RN)-C, stated R56 had not been assessed to determine if a significant change assessment was required, as R56 was expected to return to her baseline status, even though she had not within the 14 day period as required. A facility policy was requested, but not received.	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 279	Continued From page 26 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan to include coordination of care with hospice and family involvement in care, for 1 of 1 resident (R108) reviewed who received hospice services. Findings include: R108's diagnosis included a stroke with hemiplegia (paralyzed on one side), and depression. R108 was enrolled in hospice for end of life cares. The significant change minimum data set (MDS) dated 1/3/13, indicated moderate cognitive impairment, required extensive to total assistance with all activities of daily living (ADL's), received an antidepressant medication, and life expectancy was less than 6 months. R108 was interviewed on 2/12/13 at 9:20 a.m., he stated he is unable to have visitors at any time he would like. R108 stated he was dying, and it was very important to him to have his family involved in his personal cares, and to be available to assist him with things he did not wish to bother staff with, such as getting warm towels for his legs,	F 279	F 279 The facility does develop comprehensive care plans. The facility will update R108's care plan to include coordination of care with hospice and family involved in the care The Director of Social Services and Director of Nursing will meet with R108, FM-K, and FM-J to discuss what is important to the resident, visits by the family anytime, hospice services, and expectations what is allowed or not. The care plan and NAR worksheet for R108 will be updated to reflect the results of the meeting. All residents who receive hospice care had their care plan reviewed to verify the coordination of care with hospice and family involved in the care. The care plans will be reviewed at least quarterly. The Director of Social Service is responsible to monitor monthly and maintain compliance. A summary of the meeting will be presented to the Quality Improvement Committee at their next meeting.	3/18/13

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F 279	Continued From page 27	F 279		

repositioning more frequent than staff offer, among other various things that make him more comfortable. Sometimes staff let family do these things for him, sometimes they don't.
During interview with R108's family member (FM) -K on 2/12/13 at 9:30 a.m., she stated various staff had told her she could help with personal cares, others do not allow her to do so. FM-K stated SW-B had told her not to come early in the morning, as it disrupts the nurses, as they have to let her in the back door.
During interview with FM-J on 2/14/13 at 2:00 p.m. she stated some staff let her assist R108 with personal cares, others do not. FM-J stated it was important to her to be able to assist with cares.
R108's care plan dated 12/31/12 included, "Alteration in mood/behavior R/T {related to}: CVA {stroke} depression." Directions to staff included, "Allow resident to maintain some control over life by making decisions about what to eat, what to wear, when to rest, etc." The care plan did not direct to what extent family was allowed or disallowed to assist resident with cares, or to visit him, nor that family involvement was importance to R108.
R108's undated nurse aid worksheet did not include any information on what types of care family was allowed to provide or any restrictions on visiting hours.
During interview with SW-B on 2/14/13 at 3:26 p.m., SW-B stated R108's family does assist R108 with some cares, but was unclear on what those cares are. SW-B had not directed staff, in the care plan, as to what personal cares family may or may not provide, nor indicate any restrictions on visiting hours.
During interview with the director of nursing

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F 279	Continued From page 28 (DON) on 2/15/13 at 9:45 a.m., she stated she was aware family assists R108 with cares a lot, but did not know what these cares were. Family should not assist with transfers or boosting up in bed. "Washing him up is our job, if family wants to be a part of other things, that's ok. If they would come to me, I would add it to the care plan." R108's care plan failed to identify what assistance a hospice aide provides for R108. R108's care plan dated 1/3/13, included, "Terminal illness: on hospice AEB {as evidenced by} need for symptom control R/T {related to} his health decline." The goal for R108 included, "To promote dignity and comfort, reduce pain and psychological stress through the end of life process." Staff were instructed to: "...Contact hospice for condition changes, supplies or equipment needed. Coordinate care and services with hospice service and plan of care..." Added to the care plan was a form entitled Hospice Staff Role with Resident Care dated 12/7/12. This form included a hospice aide would visit one time per week on Wednesdays. Neither care plan addressed what services the hospice aide would perform for R108. During interview on 2/15/13 at 8:49 a.m. family member (FM)-J stated a hospice aide comes on Fridays to assist R108 with an extra shower for the week. During interview on 2/14/13 at 1:45 p.m. with hospice registered nurse (HRN)-L, stated a hospice aide comes once a week to assist R108 with an extra bath. It would be on the integrated care plan what the hospice aide does for R108, and what day of the week she comes. HRN-L	F 279		

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F 279	Continued From page 29 reviewed R108's care plan and verified the care plan failed to identify what care the aide would provide for R108. She stated normally it is added to care plan, but R108 just started hospice. HRN-L verified R108 was signed onto hospice on 12/6/12, over two months ago. During interview with licensed practical nurse (LPN)-D on 2/15/13 at 9:35 a.m., she stated R108 does have a hospice aide who comes on Fridays about 11:00 a.m. to give R108 a bath. LPN-D stated the information should be on the nurse aide worksheet. LPN-D found an undated nurse aide worksheet, identified as being used by nursing staff on 2/15/12. The worksheet did not include any information on when hospice would come, or what they would do for R108. Even though R108's care plan indicated a nurse aid would come on Wednesdays, the care plan did not identify the hospice aide actually came on Fridays or what services they provided for R108.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow the care plan for meal choices on a daily basis for 1 of 3 residents, R48, reviewed for choices.	F 282		

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F 282	Continued From page 30 Findings include: R48 was not given a choice of meal preferences on a daily basis according to her plan of care R48' s diagnosis include adult failure to thrive, heart failure and esophagitis. R48 ' s quarterly minimum data set (MDS) dated 12/7/12 indicated she is cognitively intact and requires assistance of 2 staff for all activities of daily living (ADL 's). R48' s care plan dated 7/17/2012 indicated staff to meet with resident before each meal. Allow resident to make choices about what to eat. A dietary note dated 12/4/12 indicated she "Receives pudding at breakfast Jello at lunch and supper. Cooks meet with resident every day to see what she would like for the day. " During interview on 2/13/13 at 10:50 a.m. R48, stated the kitchen staff used to come in before every meal and ask me what I want, but they don't anymore. Once in a great while they will come in, but not very often. They just bring me a tray and most of the time I can't eat it because it's too salty or too spicy. During interview on 2/13/13 at 2:13 p.m. with dietary manager (DM)-H stated dietary is suppose to check with R48 once a day to see what she wants to eat. During interview with on 2/14/13 at 9:34 a.m. with cook-A, stated the other cook that I replaced never told me I had to ask R48 what she wanted to eat every day, I think we ' re supposed to ask her. I didn't ask her today, I was too busy training in another person. I asked her what she wanted	F 282	**F 282** The facility does provide residents with meal choices. The facility was in error to "Cooks to meet with the resident every day to see what she would like for the day" as it would be very difficult for the cook to meet with every resident every day. The assistant dietary manager did meet with resident R48 and reviewed the weekly menu with her preferences noted on the menu. The facility also offers at least an alternate to the main meal being served. All residents have been asked if they receive the food they want and if they receive food that they don't want. The dietary aides will ask the residents if their preferences are being honored. The Assistant Dietary Manager will be responsible to make sure resident preferences are noted on their diet slip. This will also be reviewed at least quarterly at the resident's care conference. The Assistant Dietary Manager will provide information on resident preference success at the next Quality Improvement meeting.	3/13/13

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F 282	Continued From page 31 for lunch yesterday. I don' t offer the 2g meal because it's bland, I feel bad for them. Although the care plan directs dietary staff to ask R48 what she wants to eat, this was not being consistently followed as directed by the care plan. No further information provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate care with hospice services for 1 of 1 resident (R108) reviewed for hospice care. Findings include: R108's diagnosis included a stroke with hemiplegia (paralyzed on one side), and depression. R108 was enrolled in hospice for end of life cares. The significant change minimum data set (MDS) dated 1/3/13, indicated moderate cognitive impairment, required extensive to total assistance with all activities of daily living (ADL's), received an antidepressant medication, and life expectancy was less than 6	F 309	**F 309** The facility does provide care and services for a resident's highest well being. The facility will update R108's care plan to include coordination of care with hospice and family involved in the care The Director of Social Services and Director of Nursing will meet with R108, FM-K, and FM-J to discuss what is important to the resident, visits by the family anytime, hospice services, and expectations what is allowed or not. The care plan and NAR worksheet for R108 will be updated to reflect the results of the meeting. All residents who receive hospice care had their care plan reviewed to verify the coordination of care with hospice and family involved in the care. The care plans will be reviewed at least quarterly. The Director of Social Service is responsible to monitor monthly and maintain compliance. A summary of the meeting will be presented to the Quality Improvement Committee at their next meeting.	3/18/13

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F 309	Continued From page 32 months. R108's care plan dated 1/3/13, included, "Terminal illness: on hospice AEB {as evidenced by} need for symptom control R/T {related to} his health decline." The goal for R108 included, "To promote dignity and comfort, reduce pain and psychological stress through the end of life process." Staff were instructed to: "Assist resident in meeting spiritual needs. Avoid discussing information as if resident were not there. Contact hospice for condition changes, supplies or equipment needed. Coordinate care and services with hospice service and plan of care. Discuss with resident/family concerns about terminal illness and losses." Added to the care plan was a form entitled Hospice Staff Role with Resident Care dated 12/7/12. This form included a hospice aide would visit one time per week on Wednesdays. Neither addressed what services the aide would perform for R108. During interview on 2/15/13 at 8:49 a.m. family member (FM)-J stated a hospice aide comes on Fridays to assist R108 with an extra shower for the week. During interview on 2/14/13 at 1:45 p.m. with hospice registered nurse (HRN)-L, stated a hospice aide comes once a week to assist R108 with an extra bath. It would be on the integrated care plan what the hospice aide does for R108, and what day of the week she comes. The hospice aide will usually call to notify the facility when she will arrive, so that the staff knows. HRN-L reviewed R108's care plan and verified the care plan failed to identify what care the aide would provide for R108. She stated normally it is	F 309		

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F 309	Continued From page 33 added to care plan, but R108 just started hospice. HRN-L verified R108 was signed onto hospice on 12/6/12, over two months ago. During interview with trained medication aide (TMA)-A on 2/15/13 at 9:00 a.m., she stated R108 does not have a hospice aide. At 9:15 a.m. TMA-A returned and stated she had spoken to a nurse aide and R108 does have a hospice aide that comes on Fridays to give a bath. During interview with nursing assistant (NA)-H on 2/15/13 at 9:10 a.m. She stated R108 does not have a hospice aide. During interview with licensed practical nurse (LPN)-D on 2/15/13 at 9:35 a.m., she stated R108 does have a hospice aide who comes on Fridays about 11:00 a.m. to give R108 a bath. Usually they find a note at the nurses desk, the day hospice aide is suppose to come, to inform nurse aides when the hospice aide will come and what they will do. She looked and even though it was Friday, there was no note. LPN-D was not aware if there was a schedule regarding when hospice came for R108. LPN-D stated it would be on the nurse aide worksheet. LPN-D found an undated nurse aide worksheet, identified as being used by nursing staff on 2/15/12. The worksheet did not include any information on when hospice would come, or what they would do for R108. A Residential Care Facilities-Hospice Services policy dated 1/29/13, included under number 5: "Allina Hospice and the facility will coordinate, establish, and agree upon a plan of care for both providers which reflect the hospice philosophy and are based on an assessment of the	F 309		

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F 309	Continued From page 34 individual's needs and unique living situation in the facility. The plan of care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care..." Even though R108's care plan indicated a nurse aid would come on Wednesdays, the care plan failed to identify the nurse aide actually came on Fridays. In addition, there was no indication of what services the hospice aid provided for R108. The nursing home staff were not aware of when the hospice nurse aide came or what services were provided by the hospice aide for R108.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident water mugs were distributed in a manner to ensure infection was not spread for 91 of 91 residents in the building who received fresh water daily. Findings include:	F 371	**F 371** The facility does store, prepare, distribute, and serve food under sanitary conditions. The Assistant Dietary Manager did develop and provide a policy on passing water prior to exit on 2/15/13. The facility also changed the way water mugs are distributed by placing the clean mugs on the top shelf and the used mugs on the bottom shelf. This too was changed prior to exit on 2/15/13. The assistant dietary manager re-educated the dietary staff on the updated distribution method. The Assistant Dietary Manager or designee will monitor three times per week for the next four weeks for compliance by observing the delivery of the clean water mugs. The results of the monitoring will be presented to the Quality Improvement Committee.	3/18/13

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F 371	Continued From page 35 On 2/11/13 at 3:10 p.m. dietary aide (DA)-A was observed pushing a cart with full water mugs down the north hallway. DA-A was observed taking a full water mug off the cart and going in resident rooms and bringing out a used water mug, and placed it on the top shelf of the cart next to the other full, clean water mugs which were being brought into resident rooms. On 2/14/13 at 2:00 p.m. DA-B was observed pushing a cart with resident water mugs on the top shelf of the cart. DA-B was walking into resident rooms with a water mug that had a straw in, which he took off the top of the cart; and came back out of the resident room carrying a dirty water mug with a straw in his hand. He placed the dirty straws in a plastic cup, and put the dirty mug without the straw next to the clean mugs. He continued to do this process without washing his hands, even tough he was touching the dirty straws and proceeded to touch the clean mugs. At no time was DA-B observed to wash his hands. At 2/14/13 at 2:07 p.m. DA-B stated the cart is not big enough to separate the clean water mugs from the dirty water mugs; and he takes the straws out of the dirty mugs to keep track of which mugs are used by the residents. DA-B stated this is how he had been trained to pass resident water and this is how "it has always been done." During interview on 2/15/13 at 9:30 a.m. assistant food service manager (AFSM)-H stated the clean and dirty resident water mugs should be kept separate, but the facility does not have a cart big enough to keep them separate. She stated she	F 371		

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F 371	Continued From page 36 had already been looking into a bigger cart so the facility can keep the clean and dirty resident mugs separate. She stated until then they will have to collect all the used resident water mugs, and then go around and pass the clean ones using two different carts. The facility was unable to provide a policy regarding water pass for the residents No further information was provided.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the pharmacist recommendations were not followed up by the physician for 1 of 10 residents (R65), reviewed for unnecessary medications. Findings include: R65 received a daily dose Zyprexa (an anti-psychotic medication) since 12/6/2010, which	F 428	F 428 The DON does act upon the pharmacists recommendations and reports the findings to the attending physician. The facility did attempt to contact the outside (non-house) physician several times regarding the pharmacists recommendations for unnecessary medications for R65. R65 did change to a house physician. The recommendations by the pharmacist were reviewed by the house physician, the Zyprexa was deemed unnecessary and was thereby discontinued. If the pharmacist recommendations are given to any resident's physician and there is no response, the facility will contact their medical director for the review and how to proceed with the attending physician. The facility will also inform the resident of their physicians' non-compliance. The Director of Nursing will monitor monthly the pharmacist's recommendations for timely responses from the attending physicians. The Quality Improvement Committee will be informed of any non-compliant physicians.	3/18/13

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F 428	Continued From page 37 was identified by the consulting pharmacist, but the psychiatrist did not address the pharmacists concern. R65's diagnoses included: Alzheimer ' s disease, psychosis, major depressive disorder with psychotic behaviors and dementia. R65's quarterly minimum data set (MDS) dated 11/30/2012 included daily anti-psychotic. The MDS staff assessment of mood and behaviors performed by staff indicated the only indicator of depression and psychosis was: "daily refusals of assist with cares. Can be very stubborn." R65's signed physician orders dated 2/6/2013 included Olanzapine (Zyprexa) 2.5 mg (milligrams) 1 tablet orally at bedtime which was initially prescribed on 12/6/2010. R65's care plan dated 7/29/2011 included alteration in cognition and directed staff to report auditory hallucinations to nurse. Review of the target behavior sheet from January 2013 thru September 2012 did not identify any incidences of behavior for R65. R65's nurse practitioner progress note dated 11/27/12 included "...seems to have been stable with no staff reports- she is on Zyprexa. Plan: continue to monitor moods- consider further dose reductions." R65's Drug Regimen Review from 10/11 through 2/7/13 indicated on 10/9/12 a fax was sent to R65's psychiatrist indicating "primary md would like you to address Zyprexa since was ordered by you." The form was re-faxed to the psychiatrist again on 11/6/12 but there was no response by	F 428		

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F 428	Continued From page 38 the psychiatrist. During interview on 2/14/13 at 9:50 a.m. with the director of nursing (DON), she stated if the pharmacy recommends a review of a medication, the doctor will write an order in the chart. R65 just switched from an outside physician to the house physician recently. I faxed the recommendations for her Zyprexa to her primary doctor. The primary doctor told me he didn't order these medications, so I faxed it to her psychiatrist. She continued to re-fax the psychiatrist a few more times, but he never responded. During interview on 2/14/13 at 10:53 a.m. with nurse practitioner (NP)-F, she stated usually the pharmacy will give a sheet to the DON with recommendations and the DON will give the sheet to me. I don't remember getting one for R65, I usually follow up on any recommendations on her next visit, but the resident is now seeing a different NP because they have 2 NP's here now. During interview on 2/14/13 at 2:58 p.m. the DON, stated the drug regimen review dated 10/7/12 was the only one for R65. I last faxed it in October 2012 and I haven 't heard back from the psychiatrist. During phone interview on 2/15/13 at 11:29 a.m. with the facilities consulting pharmacist, he stated that he gave the recommendation sheet dated 10/7/12 to the DON and she has been re-faxing to R65 ' s psychiatrist and has not responded and the pharmacist has not followed up on the concern since. Review of undated "Drug Regimen Review "	F 428		

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F 428	Continued From page 39 policy indicates the consultant pharmacist performs the drug regimen review using accepted standards of practice, documents potential or actual medication therapy problems and communicates them to the patient's physician and/or to the director of nursing when appropriate. No further information provided.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	F 441 The facility does track resident and employee infections. The facility does discuss the findings in good faith. The employee infections will be included on the Monthly Infection Summary along with the residents in order to determine if there was a potential for cross contamination between resident and employee infections. The Director of Nursing is responsible for the completion of the updated report and the employee illness log. The DON will monitor monthly. The report will note if cross contamination occurred. The reports will be presented to the Quality Improvement Committee for their review.	3/18/13

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F 441	Continued From page 40 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure their infection control program included tracking and trending of employee infections, to determine if there was any cross contamination with resident infections. This had the potential to affect all 94 residents currently residing in the building. Findings include: During review of the facilities infection control Line Listings of Resident Infections occurring in the facility and Monthly Infection Summary reports, with the director of nursing (DON) on 2/14/13 at 9:00 a.m.. The employee infections had not been included in these reports. The DON stated the facilities staff development nurse tracked employee infections, but she did not review the employee infections to determine if there was potential any cross contamination related to resident infections that had occurred. During interview with the facilities staff development nurse (RN)-C on 2/14/13 at 9:30 a.m., she stated the DON originally gets	F 441		

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F 441	Continued From page 41 employee call in slips, but gives them to her to place on the Infection Control Tracking-Staff log. This log was not compared to the resident infection logs to determine possible cross contamination. Even though the facility tracked both employee and resident infection occurrences, the infections were not reviewed to determine if employee and resident infections were related to each other in any way. Infection Control policies and procedures were requested, but not received.	F 441		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 37 resident rooms, rooms 133, 138 and 142 reviewed for environment were free from fruit flies, which affected 5 residents in these rooms. Findings include: During observation on 2/11/13 at 2:31 p.m., of room 133, three fruit flies flying around the resident while she was sitting in her recliner. The resident was swatting at these fruit fly's.	F 469	F 469 The facility does have an effective pest control program to be pest free. The pest control company, Adams, is responsive to our needs. The Director of Housekeeping/Laundry has contacted Adam's in the past and states that they do come out when there are concerns. She has contacted Adam's about rooms 133, 138 & 142 so they can inspect and treat as necessary. She will also inform Adam's to state specifically on their reports what flies have been addressed. The Director of Housekeeping/Laundry informed her housekeepers to notify her if any areas being cleaned are not free from pests. Employees have been informed, via a posting in the employees lounge, to notify The Director of Housekeeping/Laundry if they observe areas that are not pest free. The Director of Housekeeping/Laundry is responsible for monitoring monthly and contacting the pest control company. The pest control company reports will be presented to the Quality Improvement Committee for their review.	3/18/13

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F 469	Continued From page 42 During observation on 2/15/13 at 8:55 a.m. of room 133, there were approximately five fruit flies near the residents bed and bedside table. During observation on 2/15/13 at 10:11 a.m. of room 138, there were approximately ten fruit flies near the residents bed and the light above bed. R17 who lived in room 138, stated, Yes, there are so many fruit flies in here! I swat at them all the time and can't figure out where they are coming from. I don't keep any food in here, no sugar or sweets because I know that attracts them. They were here this summer and we thought the cold weather would get rid of them, but they have gotten worse. They're everywhere! How can we get rid of them? During interview on 2/15/13 at 10:07 a.m., housekeeping-A stated, we spray the fruit flies that are in the rooms with Attack, a water-based insecticide, and use fly swatters. We have not notified pest control. We had an infestation this summer in the lunchroom and pest control told us that the fruit flies come from the drains. Residents always have food in their rooms, so it's kind of hard to keep them down. The only room that I know has a problem with fruit flies is room 138. Nobody has reported to me any other rooms. Most of the time take care of it problem ourselves. She stated they have used Adams pest control in the past. During interview on 2/15/13 at 10:45 a.m., nursing assistant (NA)-E stated, I have noticed a lot of fruit flies in room 138. During interview on 2/15/13 at 10:47 a.m., family	F 469		

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F 469	Continued From page 43 member (FM)-I was visiting her mother who lived in room 142 and stated, I have seen fruit flies in this room, I visit every other day and see them every time I'm here. She does not keep food in her room and I don't know why they are such a problem. Review of Adam's Pest Control Invoices from 8/3/2012 through 2/4/2013, did not identify that fruit flies were addressed or treated in the building on any of the visits. No further information was provided.	F 469		
F 496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program,	F 496	**F 496** The facility does regularly verify if new hires and current nursing assistants are on the registry. NA-F had met the qualifications to be continued on the nursing assistant registry. The facility did remove NA-F from the schedule, and worked with her to provide the necessary documentation to be placed on the registry with a current certificate. NA-F is now on the registry and she has been placed back on the schedule. The Director of Staff Development has verified that all current nursing assistants are on the registry. The Director of Staff Development is responsible for assuring nursing assistants are on the registry with a current certificate and will monitor by meeting with the payroll department to see if her list of nursing assistants match those of the payroll department. The results of the meeting will be presented to the Quality Improvement Committee.	3/18/13

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 _____	02/15/2013

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

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F 496	Continued From page 44 there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing assistant registry was current for 1 of 5 nursing assistants (NA)-F reviewed. Findings include: Review of NA-F employee file identitifed on 7/06/09 NA-F, transferred from the dietary department to the nursing department. There was no indication that NA-F was currently on the nursing assistant registry. On 2/14/13 at 2:00 p.m., the nursing assistant registry was contacted and the registry indicated that NA-F registry certificate had expired on 05/08/11. On 2/14/13 at 2:10 p.m., the Director of Nursing (DON) stated she was not aware that NA-F's certificate had expired and that she would be removing NA-F from the schedule until her registry was current. The DON further stated the staff development nurse had her still listed as a dietary employee so she missed checking her registration.	F 496		

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F 496	Continued From page 45 In review of the facility policy "Park River Estates Care Center Abuse and Neglect Prevention/Federal Reporting" revised 4/12 indicates they "check the appropriate licensing authorities/boards, State nurse aide registries."	F 496		

F 5448021

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

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/12/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: PATRICK SHEEHAN, SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 Pat.Sheehan@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.	K 000	POC ok PS 3-11-13 RECEIVED MAR 11 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 03.27.2013
EXIT: 02.19.2013

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

ADMINISTRATOR 3/11/13

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 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. 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 93 at the time of the survey.	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144	**K 144** The facility did have Interstate Power Systems come out on 3/6/13 and performed the annual maintenance including a load bank test and an inspection of the generator. Interstate Power Systems also re-educated the maintenance department on how to determine that the generator meets or exceeds 30% of the name plate rating or at least 75 KW. On 3/11/13, during the weekly inspection, the generator was exercised under load for at least 30 minutes and achieved 87 KW or 35%. The result was documented by the Maintenance Supervisor. The Maintenance Supervisor is responsible for the correction and will monitor to prevent a reoccurrence of the deficiency.	3/11/13

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OMB NO. 0938-0391

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

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	245448	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/12/2013

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K 144	Continued From page 2 accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on a review of available documentation, it could not be verified that the emergency generator is being properly load tested during the monthly run test and being maintained annually. This deficient practices could affect all residents staff and visitors. Findings include: At the conclusion of the facility tour on 2-12-13 at 10:30 AM, based on interview, and review of the documentation, with Director Facility Maintenance, it could not be determined, if the emergency generator is being tested to ensure that the normal operating temperature of the engine is being reached, or that 30% of name plate rating is being reached, as required by LSC(00) and NFPA 110(99). The generator is a 250 KW, fueled by diesel fuel. Nor, does the facility have on file doumentation of the annual required testing and maintenace of the generator. The generator was install 2 years ago. This deficient practice was confirmed by the Director of Facility Maintenance at the time of exit.	K 144		

F 548 021

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

Printed: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. BUILDING 02 - NEW WING B. WING _____	02/12/2013

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

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K 000	INITIAL COMMENTS Surveyor: 03005	K 000		

K 000 INITIAL COMMENTS

K 000

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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

PATRICK SHEEHAN, SUPERVISOR
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145

Pat.Sheehan@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.

DC: 03.27.2013

EXIT: 02.15.2013

POC ok
3-11-13

RECEIVED
MAR 11 2013
MN DEPT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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

ADMINISTRATOR 3/11/13

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

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K 144	Continued From page 1 This Standard is not met as evidenced by: Surveyor: 03005 Based on a review of available documentation, it could not be verified that the emergency generator is being properly load tested during the monthly run test and being maintained annually. This deficient practices could affect all residents staff and visitors. Findings include: At the conclusion of the facility tour on 2-12-13 at 10:30 AM, based on interview, and review of the documentation, with Director Facility Maintenance, it could not be determined, if the emergency generator is being tested to ensure that the normal operating temperature of the engine is being reached, or that 30% of name plate rating is being reached, as required by LSC(00) and NFPA 110(99). The generator is a 250 KW, fueled by diesel fuel. Nor, does the facility have on file doumentation of the annual required testing and maintenace of the generator. The generator was install 2 years ago. This deficient practice was confirmed by the Director of Facility Maintenance at the time of exit.	K 144	K 144 The facility did have Interstate Power Systems come out on 3/6/13 and performed the annual maintenance including a load bank test and an inspection of the generator. Interstate Power Systems also re-educated the maintenance department on how to determine that the generator meets or exceeds 30% of the name plate rating or at least 75 KW. On 3/11/13, during the weekly inspection, the generator was exercised under load for at least 30 minutes and achieved 87 KW or 35%. The result was documented by the Maintenance Supervisor. The Maintenance Supervisor is responsible for the correction and will monitor to prevent a reoccurrence of the deficiency.	3/11/13