CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: K490

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	F	acility ID: 00010
MEDICARE/MEDICAID PROVIDER (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: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF O' (L9)	WNERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY 05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other mplaint
6. DATE OF SURVEY 06/8 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	06/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 12/31	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	99 (L18) 99 (L17)	X A. In Complian Program Re Compliance1. A B. Not in Com	equirements		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A*	7. Medical Direct	tor
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNI 99 (L37) (L38)		ICF	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICABLE S	SHOW LTC CANCELI	LATION DATE):				
17. SURVEYOR SIGNATURE Brenda Fischer, U	Jnit Supervis	Date :	06/06/2016	(L19)	18. STATE SURVEY AGENCY Kate Johns Ton,	approval Program Specialis	Date: 08/03/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OR SINGLE ST.	ATE AGENCY	(==*)
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to F 2. Facility is not Eligible	TY articipate	20. COM	MPLIANCE WITH C		21. 1. Statement of Fina	ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA	1513)
22. ORIGINAL DATE OF PARTICIPATION 03/01/1987 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburse	00 INVOLUNT 05-Fail to Me	L30) CARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C	CARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION (06/15/2016	OF APPROVAL DAT	(L33)	Posted 08/03/2016 Co. DETERMINATION APPR	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245448 July 26, 2016

Mr. Thomas Pollock, Administrator Park River Estates Care Center 9899 Avocet Street Northwest Coon Rapids, MN 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 May 18, 2016, the above facility is certified for or recommended 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.

Park River Estates Care Center July 26, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 14, 2016

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

RE: Project Number S5448023

Dear Mr. Pollock:

On April 28, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 14, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 3, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 18, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 14, 2016, effective May 18, 2016 and therefore remedies outlined in our letter to you dated April 28, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	ISIT
245448 _{Y1}	B. Wing	,	Y2	6/6/2016	Y3
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).

ITEM Y4	DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix F0176	Correction	ID Prefix F0		Correction	ID Prefix		Correction
Reg. # 483.10(n)	Completed	Reg. #	3.15(h)(1)	Completed	Reg. #	483.25(h)	Completed
LSC	05/18/2016	LSC		05/18/2016	LSC		05/18/2016
ID Prefix F0406	Correction	ID Prefix F0)431	Correction	ID Prefix	F0465	Correction
Reg. # 483.45(a)	Completed	Reg. #	3.60(b), (d), (e)	Completed	Reg. #	483.70(h)	Completed
LSC	05/18/2016	LSC		05/18/2016	LSC		05/18/2016
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC		_	LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE O	F SURVEYOR		DA	TE
	` BF/kfd	6/14/2016		•	10562		<u>8/6/2016</u>
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DA	TE
FOLLOWUP TO SURVEY COMPLETED ON 4/14/2016			FOR ANY UNCORRI RECTED DEFICIENC			IE EAGULIEVO	YES NO

		POST-0	CERTIFICA	TION REVISIT F	REPORT	
_	DER / SUPPLIER / C FICATION NUMBER B		NSTRUCTION - MAIN BUILDING 0	1		DATE OF REVISIT 92 6/3/2016 93
	OF FACILITY RIVER ESTATES (CARE CENTER		STREET ADDRESS, 0 9899 AVOCET STREE COON RAPIDS, MN 5	ET NORTHWEST	DE
prograr correcte provision	n, to show those ded and the date su	leficiencies previously ich corrective action	y reported on the CN was accomplished.	care, Medicaid and/or Clinic MS-2567, Statement of Defic Each deficiency should be f wn on the CMS-2567 (prefix	iencies and Plan of ully identified using	Correction, that have been either the regulation or LSC
ITI	EM	DATE	ITEM	DATE	ITEM	DATE
Y	4	Y5	Y4	Y5	Y4	Y5
ID Prefix	x	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC	K0050	05/18/2016	LSC		LSC	
ID Prefix	x	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix	· · · · · · · · · · · · · · · · · · ·	Correction	ID Prefix	Correction	ID Prefix	Correction

Reg. #	Completed	Reg. #	Complete	d Reg.#	Completed
.SC		LSC		LSC	
D Prefix	Correction	ID Prefix	Correction	n ID Prefix	Correction
Reg. #	Completed	Reg. #	Complete	d Reg. #	Completed
.SC		LSC		LSC	
D Prefix	Correction	ID Prefix	Correction	ı ID Prefix	Correction
Reg. #	Completed	Reg. #	Complete	d Reg. #	Completed
.SC		LSC		LSC	
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.SC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) TL/kfd	DATE 6/14/2016	SIGNATURE OF SURVEYOR	19251	DATE 6/3/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVE 4/14/2016	Y COMPLETED ON		DR ANY UNCORRECTED DEFICECTED DEFICIENCIES (CMS-25		
Form CMS - 2567B (09/92	2) EF (11/06)		Page 1 of 1	EVENT I	D: K49022

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building 02 - NEW WING				
245448 _{Y1}	B. Wing	Y	/ 2	6/3/2016	Y3
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).

ITEM Y4	DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. # NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC K0050	05/18/2016	LSC			LSC		-
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		-
ID Prefix	Correction	ID Prefix	_	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		=
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		-
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		-
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) TL/kfd	DATE 6/14/2016	SIGNATURE OF	SURVEYOR 192	251	DATE 6/3	/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	. 32		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 4/14/2016			R ANY UNCORREC			IE EA OU IEVO	s 🗆 no

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: K490 Facility ID: 00010

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1. MEDICARE/MEDICAID PROVIDE (L1) 245448 2.STATE VENDOR OR MEDICAID NO. (L2) 426040600		3. NAME AND AL (L3) PARK RIVE (L4) 9899 AVOCI (L5) COON RAP	ER ESTATES (ET STREET N	CARE CE		4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	ON: <u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint
6. DATE OF SURVEY 04/14 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	L/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	DING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	99 (L18) 99 (L17)	Compliance1. A X B. Not in Con	equirements e Based On: cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B*	6. Scope of 9	Services Limit Director om Size
14 AMO CERMINED DED DREAMS	ND.	requirements	una or rappineu	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		(2.2)	
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 99	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Michelle Thompson. HF	E NE II	0	05/12/2016	(L19)	Kamala Fiske-Downing, Hea	Ith Program Repres	entative 06/10/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY	
DETERMINATION OF ELIGIBIE 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Control3. Both of the Above	ol Interest Disclosure Str	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	,	(L30)
OF PARTICIPATION 03/01/1987	BEGINNING		ENDING DA		VOLUNTARY 000 01-Merger, Closure	INVOLU	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE: (L27)	A. Suspensio	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	der Status Change e
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)	00 001		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 28, 2016

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

RE: Project Number S5448023

Dear Mr. Pollock:

On April 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338

Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 24, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

Park River Estates Care Center April 28, 2016 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

Park River Estates Care Center April 28, 2016 Page 5

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Park River Estates Care Center April 28, 2016 Page 6

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

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Enclosure

cc: Licensing and Certification File

PRINTED: 05/13/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE COMF	SURVEY PLETED
		245448	B. WING _	·····	04/1	4/2016
	PROVIDER OR SUPPLIER VER ESTATES CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH COROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN ⁻	rs	F 00	00		
	as your allegation of Department's acceptoriolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 176 SS=D	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with NT SELF-ADMINISTER	F 17	76		5/18/16
	the interdisciplinary	ent may self-administer drugs if team, as defined by as determined that this				
	by: Based on observatoreview, the facility for residents (R130) wo cessation product (order or assessment medications. Findings include: R130's undated Admultiple diagnoses sclerosis, chronic is	ition, interview, and record ailed to identify 1 of 1 ho utilized a smoking gum), and did not receive an int for self administration of mission Record identified which included multiple schemic heart disease, entia. In review of the last		The facility has modified the acassessment in order to identify cessation products are being u cessation products are being u physicians order for self adminise assessment will be completed. physician order was received for use nicorette gum and a self administration assessment was completed. Based upon the assessment is not safe to self administration. The gum was removed from the gum. The gum was removed from the discontinuous products as the self administration.	if smoking sed. If sed, a istration will tration A or R130 to sessment, ster the	
ABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

Electronically Signed

05/04/2016

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 176	R130 had a BIMS cognitive deficit. Ac R130 required exterpersonal cares. R1 12/29/15 indicated A Self-Administratidated 12/21/15, incomplete administer meself-administering and R130 had no complete administering and interdisciplinary teacognitive, physical, this responsibility." During interview 4/observed chewing was Nicorette, and in the top drawer of drawer was observed able to be locked. On 4/13/16, at 9:4' the dining room fin Nicorette gum was breast shirt pocket.	Data Set (MDS), dated 3/18/16, of 8 indicating moderate dditionally, the MDS identified ensive assistance with all 30's admission MDS dated he had no tobacco use. On of Medication Evaluation, dicated R130 did not want to dications, was not medications prior to admission, order to self-administer e plan identified "The resident itive function/ thought to) DX (diagnosis) of at has some forgetfulness." e entitled: Self Administration of ed 4/15) directed "If a resident minister drugs, the am must assess the resident's and visual abilities to carry out	F 176	room and is being administered to nursing staff. R130's wife was infi that all future cessation products given to the nursing staff. All curr residents will be asked if they use smoking cessation products on on their next quarterly care conferent quarterly there after. Nursing staff informed of the updated admission assessment. The DON and LSW responsible to monitor the residence will initiate a self administration assessment if the resident is using cessation product(s) and desires administration for compliance. The updated admission assessment where the presented at the next Quality Assand Performance Improvement in July 2016	ormed must be ent er r before ce and f will be on will be es and g self le vill be urance		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245448	B. WING			04/	14/2016
	PROVIDER OR SUPPLIER VER ESTATES CARE	CENTER		98	TREET ADDRESS, CITY, STATE, ZIP CODE 899 AVOCET STREET NORTHWEST OON RAPIDS, MN 55433	, , ,	
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F 176	wheelchair, chewin Nicorette gum was pocket. During further inter R130 stated the Nichis wife and had nestated "staff must knever talked to him R130 could not starchewed in a day or the gum. During the Nicorette gum were table and 4.5 bliste	g a piece of gum. The piece of no longer in the left breast view on 4/13/16, at 1:23 p.m., corette gum was brought in by ever told staff about it. R130 know" about the gum but had regarding use of the gum. It is how often his wife supplied the interview, four pieces of the observed on R130's bedside r packs were observed in the	F 1	76			
	contained 4 mg (mi box of gum contain During observation R130 was observed watching TV. On 4/14/16, at 10:4 nurse (LPN)-A state couple of times che what kind of gum h resident had a med physician would habe self-administere	rawer. Each piece of gum illigrams) of nicotine and a full led 220 pieces. on 4/14/16, at 10:05 a.m., d chewing on gum while 12 a.m., licensed practical led R130 was observed a lewing gum, and did not know e chewed. LPN-A stated if a lication by the bedside, the lication to ad and then assessed by the license and license at the license and license and license at the license and license at the license and license at the l					
	responsible to performer resident to ensure some stated R130 chewer did not know how fir what kind of gum it	orm monthly checks on any safety. 1 4/14/16, at 12:51 p.m., LPN-B and gum in the dining room, but requently he chewed gum or					

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F 176	(NA)-A stated chew R130 did after gett was uncertain of the On 4/14/16, at 12:5 (RN)-A was unaware and had not coded During interview or director of nursing been admitted with were there any ord the previous facility dependence. The I would be considered to assess R130 for medications and keep The DON would not R130 what type of	ving gum was the first thing ing up in the morning. NA-A le type of gum R130 chewed. 55 p.m., registered nurse re of R130's use of Nicorette of his history of tobacco use, his use on the MDS. 14/14/16, at 1:30 p.m., the (DON) stated R130 had not orders for Nicorette gum nor ers or admission papers from	F 17	76		
	interview they were gum use, he openl and received staff addition, he travele	acility staff indicated through a unaware of R130's Nicorette by stored the gum in his room assistance with all cares. In the different throughout the facility with a hanging out of his pockets.				
	R130's wife indicat Nicorette since adr supplied him with to a total of 440 piece of how many piece stating it was "a lot	view on 4/18/16, at 2:54 p.m., ed he had been using mission to the facility. She wo boxes of gum a month, for es. R130's wife was not aware s R130 chewed in a day ." She believed the facility was um use, but stated the facility				

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F 176	Review of R130's p 3/7/16, identified no	ge 4 d him to administer it. hysician orders, signed on orders for Nicorette gum nor 30's ability to self-administer	F 17	6	
F 252 SS=E	medications. In review of the man product label read "and pets," "Do not uday," and directed obefore use if you haheart attack, or irregard and must be used a results." 483.15(h)(1)	nufacturer's instructions, the Keep out of reach of children use more than 24 pieces a consumers to "Ask a doctor ave heart disease, recent gular heartbeator diabetes." "Nicotine gum is a medicine a certain way to get the best	F 25	2	5/18/16
	the resident to use to the extent possible. This REQUIREMENT by: Based on observate review, the facility fadining environment (Enhanced dining, This had the potential).	melike environment, allowing his or her personal belongings		The facility will fully eliminate the u trays in the enhanced and transition care unit dining rooms effective 5/5 thus providing a more homelike environment. All meal items will be removed from the trays and placed table. The new serving system will audited by the Director Food Servic weekly for one month for each meaning ensure accuracy an efficiency of services.	on the be twice al to

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F 252	During observation main dining room, residents were sea with seating for for covered in aqua county and pepper shake holder, utensils, erprotectors. The restyle, with dietary at their lunch meal and of the residents for used to serve the during the lunch mused to serve the during the lunch mused to serve the during the lunch mused to serve the during and the glasses or in front of the residents for four restables had clothing table spot. The erpassing residents leaving the residents leaving the resider front of the resider opening cartons of and placing the enlids stacked in the residents were eat. During interview 4, supervisor (DS)-A using trays for the room a couple more sidents.	n of the meal service in the on 4/12/16, at 11:50 a.m., ated at several square tables ar residents. The tables were blored tablecloths and held salt rs, a menu in an upright plastic mpty plastic cups, and clothing sidents were served restaurant aides serving beverages and and placed it on the table in front r them to eat. No trays were residents in this dining room real in the main dining room real in the main dining room. 1. 4/12/16, at 12:00 p.m. in the six residents were observed restic trays. Staff began to serve stic trays. Staff left the plates on the tray and placed the meal dent. 1. 4/12/16, at 12:10 p.m. regroom had six tables with sidents at each table. The protectors at each resident's shanced dining room staff were their meal on the serving tray in the serving tray in the table. Staff was a fuice and milk for the residents repty containers in the thermal middle of each table where	F 2	252	The Director Food Service will be responsible for ongoing compliance results of the audit will be presente next Quality Assurance and Perfort Improvement meeting in July 2016	d at the mance	

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F 252 F 323 SS=D	stated the facility wall of the dining roo been developed on Further, DS-A state the thermal plate coand using them to such the thermal plate coand using them to such the served or family member state residents served or they serve the food be nice if they would tables and remove more home like for A policy was reques none was provided 483.25(h) FREE OHAZARDS/SUPER. The facility must erenvironment remains is possible; and	ould like to stop using trays in ms, however no plan had how to accomplish this. d staff should not be placing overs in front of the residents store garbage. 4/13/16, an anonymous ed they did not like seeing the n trays, "I don't understand why on trays. I really think it would d just put the plates on the the trays. It would make it them."	F 2			5/18/16
	by: Based on observation revitation residents who smoke safely, even	NT is not met as evidenced tion, interview, and ew the facility failed to ensure smoked had been assessed to with assistance of family and esidents (R13, R74).		The facility has developed a new smoking policy which includes per a smoking assessment of current residents and quarterly thereafter, smoking is confined to the area or designated for smoking and that a resident's family or friend must	forming itside	

CLIVILI	13 I ON WILDICANE	& WILDIGAID SLITVIGES			U	IVID IVO.	0930-0391
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				C	OON HAPIDS, WIN 55455		
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F 323	R13's diagnoses from Record included more (complete paralysis obstructive pulmonal vascular disease, and dysfunction. R13's Data Set (MDS) data was cognitively inta A Care Area Assess Falls dated 1/15/16 staff performance for R13's care plan data continued to smoke An interview on 4/1 revealed the smoking red pouch attached the spouse took R1 stated the spouse for cigarette. On 4/13/16, at 9:41 (NA)-B stated staff smoke. R13 only with smoke. R13 only with smoke. On 4/13/16, at 11:5 (LPN)-B indicated from the cigarettes and light brought R13 outsid On 4/14/16, at 8:58 (DON) stated reside campus but have to bring them outside the residents are alta materials. The DON assessment complete.	om the undated Admission altiple sclerosis, hemiplegia of half of the body), chronic ary disease, peripheral and neuromuscular significant change Minimum ated 1/15/16, indicated R13 and currently used tobacco. Siment (CAA) worksheet for all mobility and cares. The december of the wheelchair and the wheelchair and stated 3 outside to smoke. R13 and the cigarette, and extinguished a.m. with nursing assistant do not take R13 outside to went outside with the spouse to a stated R13's spouse had the er for R13 and the spouse	F	323	accompany the resident to the outs designated area. The smoking assessment was updated to asses residents' ability to smoke safely in to have the resident acknowledge. Park River Estates Care Center is smoke-free building. R13 & R74 w assessed to smoke safely and quathereafter. Both residents will be gicopy of the new smoking policy. The smoking policy will be included in the admission packet. Effective 5/12/1 lighters, matches, e-cigs or tobacc products are allowed to be stored of facility premises with the exception will have the option of keeping their smoking supplies in a locked meditoroom. A sign indicating "Designate Smoking Area" has been ordered as be placed in the all ready establish designated area located approximate feet west of the main entrance. The smoking policy and updated asses will be reviewed with all nursing an service staff. The LSW is responsion ongoing compliance including reviet the policy with R13 & R74 at their quarterly care conferences. The LSDON will present the new policy ar updated assessment at the next Q Assurance and Performance Improvement meeting in July 2016	s the cluding that a fill be arterly ven a fill be on the fill of R13 and who recation d fill ed for exercise for ewing SW & and fill uality	
		e to locate it. Further the DON					

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F 323	stated while the results was responsible for A smoking policy with provided. R74's diagnoses listed 3/16/16, inclipulmonary disease weakness, and nicula admission Minimur 3/24/16, indicated required extensive hygiene and dressile eating, and current Assessment (CAA) daily living (ADLs), required staff assisted to impaired mointolerance. R74's indicated R74 was On 4/12/16, at 9:08 stated R74 smoked came to the facility would take her out not allowed to take RN-A stated there completed for R74 oriented. She's with During an interview stated she was onlifamily visited and secigarettes herself. Cigarettes and light kept her jacket in houring an observat R74's family member wheelchair, and pla located just outside	sidents are at the facility staff r them. ras asked for and but not sted on the Admission Record, uded chronic obstructive et, lung cancer, muscle otine dependence. R74's m Data Set (MDS), dated R74 was cognitively intact, assistance for personaling, was independent with ely used tobacco. A Care Area of worksheet for activities of dated 3/23/16, indicated R74 stance with mobility and ADLs obility, pain, and activity care plan dated 4/12/16, a "Current cigarette smoker." B a.m., registered nurse (RN)-A dicigarettes, and her family at least once a day. Family to smoke because staff was residents outside to smoke. Was no smoking assessment because she was, "Alert and in the program." on 4/12/16, at 2:44 p.m., R74 y allowed to smoke when her she could light and hold the R74 stated she kept her ter in her jacket pocket, and	F 32	3		

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F 323	pack, took out a ligher mouth, and lit the cigarette while talking and occasionally rewheelchair and flick concrete. When R7 the cigarette to herextinguished by steheld it briefly to ensand disposed of it in the facility. During an interview RN-B stated reside can't smoke in the were expected to k Residents were not materials in the fact assessment had not R74 could smoke sinvolved at all with During an interview licensed social worn not completed an accould smoke safely supervised smoking part of my job that During an interview stated the staff on tunit (TCU) always knurse's station, but her current room stated there was or wandered into her lobserved going three observed going three was provided to the staff on the stated there was or wandered into her lobserved going three observed going three was provided to the staff on the stated there was or wandered into her lobserved going three observed going three was provided to the staff on the stated there was or wandered into her lobserved going three observed going three was provided to the staff of the staff of the stated there was or wandered into her lobserved going three observed going three	sigarette from the cigarette hter, placed the cigarette in he cigarette. R74 smoked the ng with her family member ached her left hand beside the ked the ashes onto the 74 was finished, she handed family member, which he pping on it, picked it up and sure it was no longer burning, in the trash by the entrance of 7 on 4/13/16, at 9:40 a.m., into that smoke knew they building and family members eep the smoking materials. It allowed to keep their smoking ility. RN-B stated an 10 to been completed to ensure 11 affect of 12. The first on 4/13/16, at 3:01 p.m., where (LSW)-A stated she had 12 seessment to ensure R74 to because, "We don't offer g." LSW also stated, "It's not 14 know of." If on 4/13/16, at 3:08 p.m., R74 the attached transitional care (expt her cigarettes at the since she was transferred to the has kept her package of ighter in her jacket pocket and the closet in her room. R74 the resident that often froom. The resident was bugh pockets of R74's	F 3.	23		
	bathrobe that was	draped over the chair. R74 would often take things from				

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F 323	DON stated, "We do residents that smoke oriented, we kind on DON stated family responsible for taking and they could kee their room. The DO in the facility that we and it was possible the smoking matering a follow up in p.m., the DON verificompleted for R74 safely. A facility smoking protection provided. 483.45(a) PROVID REHAB SERVICES If specialized rehabilitative and mental retardaresident's comprehemust provide the receptive services from accordance with §4 provider of specialis.	om. on 4/14/16, at 8:59 a.m., the lon't do an assessment [for ke]. If they are alert and f go off their cognition." The or other visitors were ng the residents out to smoke, p their smoking materials in on stated there were residents andered into residents' rooms for them to have access to ials and stated, "Yes, we are ryone's safety." Interview on 4/14/16, at 2:42 fied an assessment was not to ensure she could smoke solicy was requested, but was E/OBTAIN SPECIALIZED collitative services such as, but ical therapy, speech-language ional therapy, and mental eservices for mental illness tion, are required in the ensive plan of care, the facility equired services; or obtain the rom an outside resource (in 183.75(h) of this part) from a zed rehabilitative services.		323 406			5/18/16
	This REQUIREME	NT is not met as evidenced					

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F 406	facility failed to ensigned facility failed to ensigned for 1 of 1 assessed with interpretable followed for 1 of 1 assessed with interpretable for 1 of	w and document review, the sure a level II Preadmission sident Review (PASSRR) was resident (R2) who was ellectual disabilities. ecord face sheet dated 3/7/16, admitted to the facility on were intellectual disability, oral palsy. R2's care plan he had impaired cognitive that processes related to severe the cerebral palsy and dementia. eport Level II Preadmission cons with Mental Retardation cons indicated R2 was evaluated posed date of admission to this. The Level II was completed by and indicated R2 had mental the required NF (nursing facility) and indicated R2 had mental that is reactive treatment. The local at all active treatment needs and in this person's individual will be met while this person	F4	The facility does ensure completed and reviews the resident being accepadmission. Hennepin Contacted regarding the need for a level II screen Hennepin County contacted regarding the need for a level II screen Hennepin County contacted regarding the attempt of screening by right to decline it. I will be paperwork soon." The reflection Hennepin County will be R2's medical record after are no other current resistate level II screening or treflection. The LSW will county if a possible admited admission. The LSW will county if a possible admited level II screening & treat screening results in active LSW will also monitor to receives active treatment required. The report from County will be reviewed Assurance and Performating Improvement meeting in	the results prior to oted for punty was documented ning for R2. Cted R2's ed our LSW on Completed the phone-it is his e submitting the esults from documented in er receipt. There idents that require eatment. The nonitor that all I prior to II work with the dission requires a timent. If R2's we treatment, the make sure R2 at as long as it is m Hennepin at the next Quality ance	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO T	D BE	(X5) COMPLETION DATE
F 431 SS=B	further indicated He (developmentally d admission and to c On 4/14/16, at 9:22 (LSW)-A stated R2 treatment and she nursing home she c LSW-A stated she completed 7/1/98, v group home. LSW-that another level II no longer needed a On 4/15/16, at 3:00 Hennepin county st completed 7/1/98 a receiving active treal. 483.60(b), (d), (e) I LABEL/STORE DR The facility must er a licensed pharmac of records of receip controlled drugs in accurate reconciliar records are in orde controlled drugs is reconciled. Drugs and biological labeled in accordar professional princip appropriate access	olvement." The authorization ennepin County DD isabled) unit approved ontact them for paperwork. It a.m. licensed social worker was not receiving active thought since she was in a did not need active treatment. Thought the Level II that was was when she was at the A stated she was not aware was completed indicating she active treatment. It p.m. a DD supervisor from the last Level II was not indicated that R2 should be atment according to the Level DRUG RECORDS, BUGS & BIOLOGICALS Inploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an aution; and determines that drug or and that an account of all maintained and periodically als used in the facility must be not with currently accepted oles, and include the	F 4			5/18/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245448	B. WING		04/14/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 431	facility must store a locked compartme controls, and perm have access to the The facility must p permanently affixe controlled drugs list Comprehensive Di Control Act of 1970 abuse, except whe package drug districted	a State and Federal laws, the all drugs and biologicals in ents under proper temperature nit only authorized personnel to e keys. Tovide separately locked, d compartments for storage of sted in Schedule II of the rug Abuse Prevention and and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose can	F 43		
	by: Based on observareview, the facility medications (store for anybody in the resident use, and it to affect 45 of 45 r and West units of survey. Findings include: The facility's Stand dated 4/15, identifity which they could redays as needed for no results from support to the following the following the facility of the facility is standard for the facility is	ation, interview, and document failed to ensure stock filled and medications that can used facility) were available for not expired. This had potential esidents residing in the East the facility at the time of the ding Orders for Long Term Care ed orders for all residents in eceive an enema every three or constipation, if resident had opository.		The facility updated the system to for expired medications including the stored in the medication rooms and refrigerators. The night shift nursed been designated to check weekly for expiration dates on all medications medication room and refrigerator. A guideline, medications that will expirate the DON will review the updated monitoring system with the nurses. DON will audit one medication room refrigerator each week for three we assure compliance and the results presented at the next Quality Assur and Performance Improvement med July 2016. The DON is responsible ongoing compliance.	nose I nad or in the As a ire in erly. The n and eks to will be ance eting in

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		245448	B. WING _		04/	14/2016
	PROVIDER OR SUPPLIER VER ESTATES CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	practical nurse (LP three boxes of unopenemas with an exstated the enemas and were available expired and should further review, the opened vial of Tube for tuberculosis) wire 2/21/16. LPN-C states on 2/21/16, and waskin tests for new right will will be for reside discarded after 30 of Further, LPN-C states monitored the medications were right of the modifications were resided to grooms to ensure must have a saigned to grooms to ensure must ha	t 10:15 a.m. with licensed N)-C, a cupboard contained bened, stock, saline laxative piration date of 8/15. LPN-C were on the standing orders for resident use, but were have been replaced. Upon refrigerator contained an exculin protein (used for testing tha handwritten date of ted the solution was opened s used to administer tuberculin esidents on the East and West. LPN-C stated the vial was not use, but should of been days of being opened. The days of being opened. The days of being opened are severely experied. In p.m., the director of nursing reses were responsible to go atton carts, but no one had ever of through the medication edications were not expired. Medications To Date When ocated in a Medication ord (MAR) binder located on ication cart. The form culin solution should be	F 43	1		
	483.70(h)	AL/SANITARY/COMFORTABL	F 46	5		5/18/16

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG		E SURVEY PLETED
		245448	B. WING		04/	14/2016
	PROVIDER OR SUPPLIER VER ESTATES CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 9899 AVOCET STREET NORTHWES COON RAPIDS, MN 55433	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 465	Continued From particles of the facility must prosanitary, and comforesidents, staff and This REQUIREME by: Based on observation failed to ensure a swas maintained for W126, W144) reviet and 5 of 5 resident N134, W146) reviet cracks, and walls in Findings include: On 4/13/16, at 11:0 completed with the and the following elidentified: CEILING TILES: Resident room W1 white suspended costains. MD measur five ceiling tiles who 1: Ceiling tile measur brown, stained area 7".	rovide a safe, functional, ortable environment for if the public. NT is not met as evidenced tion and interview, the facility safe and sanitary environment of 3 of 3 resident rooms (W143, ewed with ceiling tile damage, rooms (N135, N140, N133, ewed with loose grab bars, in disrepair. Of a.m. a facility tour was a maintenance director (MD), invironmental concerns were eiling tiles which had brown ed the tiles and staining on the ich identified: sured 2' (feet) x (by) 4' with a a that measured 3" (inches) x	F 4	DEFICIENCY)	a resident checking the loors, grab e items in pe completed nent. The or all resident ecklist was 135, N140, I all repairs will be completed, naintenance of the re. The esponsible for ew checklist lists for , N133, N134 at the next ormance	
	stained area that m 3: Ceiling tile meas stained area that m 4: Ceiling tile meas stained area that m	sured 2' x 4' with a brown, neasured 2.5" x 2.5". sured 1' x 4' with a brown,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245448	B. WING _		04	/14/2016	
	PROVIDER OR SUPPLIER VER ESTATES CARE			STREET ADDRESS, CITY, STATE, ZIP 9899 AVOCET STREET NORTHWE COON RAPIDS, MN 55433	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 465	Stained area that covered the entire ceiling tile, 1' x 4'. W126's bathroom was observed to have two white suspended ceiling tiles which had brown stains, in addition, two ceiling tiles were found not properly seated in the divider rails. MD described the two tiles as follows: 1: Ceiling tile measured 19" x 47" with a brown, stained area that covered the entire ceiling tile, 19" x 47". 2: Ceiling tile measured 24" x 42" with a brown, stained area that covered the entire ceiling tile, 24" x 42". MD stated bathroom tiles have "always" been a problem as moisture drips down and stains the tiles. MD further stated ceiling tiles should be placed correctly in the rails. MD identified the stains were through the entire tile on both of them.		F 40	55			
	suspended ceiling had brown stains. I measured 2' x 4' w measured 4.5" x 9' may have become conditioning sweat tile." GRAB BARS/ROC N135 was observe grab bar located be In addition, an app observed in the int the grab bar. MD a	ed to have one white tile, near the ceiling vent which MD stated the ceiling tile ith a brown, stained area that ". MD stated the ceiling tile stained from the air ing adding, "I will replace this of the have a loose and wobbly etween the sink and the toilet. The roximate 3" crack was be rior surface of the wall behind to greed the grab bar was loose stress crack behind the grab the trills."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245448	B. WING _		04	1/14/2016	
	ARK RIVER ESTATES CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 465			STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433			
PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 465	•		F 46	55			
	grab bar located be MD stated the grab	etween the sink and the toilet.					
	grab bar located be MD stated he would	etween the sink and the toilet. d tighten the grab bar, "I was					
	crack on the interio the grab bar. There marks and gouges MD stated there wa bar, and he would t stated the scrapes	or surface of the the wall behind e were also several black scuff on the wall in the bathroom. as a 3" crack behind the grab tighten the grab bar. MD also and gouges on the wall should					
	marks and gouges wall. Two areas on sheetrock. MD stat likely from the resid several scuff marks wall in this room. F	on the lower portion of the a this wall also had exposed ed the wall was in disrepair dent's wheelchair; there were son the lower portion of the further, MD stated the scuffing					
	preventative mainte grab bars on a mor should also be letting grab bars are loose aware any of the grap were loose until you stated loose fitting issue" and they sho	enance book and checked the onthly basis. MD stated staffing him know if they noticed ening or in disrepair, "I was not rab bars we looked at today					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		E SURVEY MPLETED
		245448	B. WING		04/	/14/2016
	PROVIDER OR SUPPLIER	CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
F 465	replaced. When interviewed of facility administrato	ge 18 ed and should have been on 4/13/16, at 1:08 p.m. the r stated the facility had no ceiling tiles or checking grab	F4	465		

F5448024

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		B. WING			04/14/2016		
NAME OF PROVIDER OR SUPPLIER PARK RIVER ESTATES CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	rs	K 0	00			
	FIRE SAFETY						
et	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
i	ONSITE REVISIT OF CONDUCTED TO VISUBSTANTIAL CORREGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Marshal Division on this survey, Park Rifound not in complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the pent of Public Safety, Fire April 14, 2016. At the time of over Estates Care Center was ance with the requirements for icare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety or 19 Existing Health Care.					
	PLEASE RETURN CORRECTION FOR DEFICIENCIES (K-	R THE FIRE SAFETY		EPO(
: :	Healthcare Fire Insp State Fire Marshal I 445 Minnesota St., St. Paul, MN 55101-	Division Suite 145					
	By email to: Marian.Whitney@st	ate.mn.us,and				(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/04/2016

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.

CENTE	42 FOR MEDICARI	E & MEDICAID SERVICES			CIVID IVC	0. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG 01 - Main Building 01		TE SURVEY MPLETED	
		245448	B. WING _		04	/14/2016	
NAME OF PROVIDER OR SUPPLIER PARK RIVER ESTATES CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433				
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K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or properties of the correct the defice 3. The name and/oresponsible for corprevent a reoccurred at a district of the constructed at 3 districted at	n@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done	K 00				
K 050	NOT MET as evide	42 CFR, Subpart 483.70(a)is nced by: FETY CODE STANDARD	K 05	0		5/18/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448			(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED 04/14/2016	
		B. WING _					
NAME OF PROVIDER OR SUPPLIER PARK RIVER ESTATES CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433			
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K 050 SS=D	signal and simulat conditions. Fire dritimes under varyin on each shift. The and is aware that croutine. Responsitions who are quitines who are quitines with a coded a conducting drills are coded and the coded an	the transmission of a fire alarm on of emergency fire as a least quarterly staff is familiar with procedures drills are part of established willing for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms. This is not met as evidenced by: Intation review and staff at the drills on the conduct fire drills are all residents in the event of ency in accordance with	K 05	The facility will conduct fire dri varying times at least quarterly shift. A schedule has been dev varied times with at least 1.5 h between the previously schedu. The facility did conduct a fire d 25, 2016 at 7:30 am. The direct maintenance is responsible for compliance for varied times. The schedule will be reviewed at the Quality Assurance and Perform Improvement (QAPI) meeting.	on each eloped with ours in iled drill. rill on April tor of monitoring ne e July 2016		

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

PRINTED: 05/06/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - NEW WING 245448 B. WING 04/14/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9899 AVOCET STREET NORTHWEST PARK RIVER ESTATES CARE CENTER COON RAPIDS, MN 55433 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on April 14, 2016. At the time of this survey Park River Estates was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us, and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/04/2016

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.

Facility ID: 00010

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

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	ILM OF DEFICIENCIES TAX PROVIDENCES FUEL CONTINUES TO TAX PROPERTY OF TAX PROP		I ' '	TE SURVEY MPLETED		
		245448	B. WING _		04	/14/2016
	PROVIDER OR SUPPLIER VER ESTATES CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of verto correct the deficition of verto correct this wing onto Park constructed in 2011 no basement. The determined to be ty separated from the fire rated construction fire doors.	RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. c River Estates was . It is a one story building with construction type is pe II(111). The building is rest of the facility by 2 hour on , with a 1 & 1/2 hour rated	K 00			
	facility has a complesystem, with smoke spaces open to the automatic fire deparesident rooms hav detectors that transfacility is licensed for at the time of inspension.	sprinkler protected. The ete automatic sprinkler detection in the corridors and corridor, that is monitored for rtment notification. All e single station smoke mit to the nurses station. The or 99 beds with a census of 91 ction. 42 CFR, Subpart 483.70(a)is				
K 050 SS=D	NOT MET as evide NFPA 101 LIFE SA Fire drills include th signal and simulation		K 05	50		5/18/16

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

PRINTED: 05/06/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW WING			(X3) DATE SURVEY COMPLETED	
		245448	B. WING			04/	14/2016
	PROVIDER OR SUPPLIER VER ESTATES CARE	CENTER		98	REET ADDRESS, CITY, STATE, ZIP CODE 1999 AVOCET STREET NORTHWEST OON RAPIDS, MN 55433		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050	on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are query where drills are conducted and a coded and instead of audible at 18.7.1.2, 19.7.1.2. This STANDARD is Based on document interview, the facility under varying times response to evacua a fire or an emerge LSC(00) section 18. Findings include: On facility tour betwand 3:30 PM on 4/1 review it was reveal Day-shift fire drills be AM, 10:15 AM, 10:15 times as required.	g conditions, at least quarterly staff is familiar with procedures rills are part of established lity for planning and assigned only to competent ualified to exercise leadership inducted between 9:00 PM and innouncement may be used larms. Is not met as evidenced by: intation review and staff y did not conduct fire drills is. This could affect the staff inte all residents in the event of incy in accordance with	KO	150	The facility will conduct fire drills at varying times at least quarterly on eshift. A schedule has been develop varied times with at least 1.5 hours between the previously scheduled. The facility did conduct a fire drill o 25, 2016 at 7:30 am. The director of maintenance is responsible for mo compliance for varied times. The schedule will be reviewed at the Ju Quality Assurance and Performance Improvement (QAPI) meeting.	each ed with in drill. n April of nitoring	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted April 28, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5448023

Dear Mr. Pollock:

The above facility was surveyed on April 11, 2016 through April 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Park River Estates Care Center April 28, 2016 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING _ 00010 04/14/2016

	VER ESTATES CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING CORRECTION ORDE	R				
	In accordance with Minnesota Statute, see 144A.10, this correction order has been is pursuant to a survey. If, upon reinspection found that the deficiency or deficiencies of herein are not corrected, a fine for each wonot corrected shall be assessed in according with a schedule of fines promulgated by rethe Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the transmer and MN Rule number indicated be When a rule contains several items, failure comply with any of the items will be considered for compliance. Lack of compliance to re-inspection with any item of multi-part rule result in the assessment of a fine even if that was violated during the initial inspection corrected.	ssued on, it is ited riolation dance ule of been ag below. re to dered upon ule will the item				
	You may request a hearing on any assess that may result from non-compliance with orders provided that a written request is notice of assessment for non-compliance	these nade to of a				
	INITIAL COMMENTS: You have agreed to participate in the electroceipt of State licensure orders consisted the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/probul.htm The State licensing orders are delineated on the attached Minnesota	nt with				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

(X6) DATE 05/04/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		00010		B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARK RI	VER ESTATES CARE	CENTER		CET STREE PIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CIENCIES DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From particles of Heart you electronically is necessary for State enter the word "corrected. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff of the following correction that you and identify the date.	Althorders being Although no plate Statutes/Rurected" in the bess, under the edate your ordectronically supent of Health. 4/14/16, surveyisited the about on orders are our electronic have reviewed a when they wis	an of correction ales, please box available for electronic e heading ders will be bmitting to the eyors of this we provider and e issued. plan of these orders, ll be completed.	2 000			5/18/16
	or related disorder to ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144. (a) If a nursing facil Alzheimer's disease or related or generate staff and their supervisor care. (b) Areas of require (1) an explanation or related disorders; (2) assistance with (3) problem solving and (4) communication	EASE OR RELING: 6503 ity serves persilisorders, where the service it is a constant of training included activities of day with challenging in the service in	ons with ther in a cility's direct ned in dementia ide: disease and ily living;				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00010		B. WING		04/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	00010	STREET AD	DRESS CITY S	STATE, ZIP CODE	04/1	7/2010
	VER ESTATES CARE	CENTED			T NORTHWEST		
PARK RI	VER ESTATES CARE	CENTER	COON RA	PIDS, MN 5	5433		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 2		2 302			
	(c) The facility shall written or electronic training program, the trained, the frequentopics covered. (d) The facility shall this section.	form a desc ne categories ncy of training	cription of the sof employees g, and the basic				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided written or electronic information regarding training staff had received for dementia and/ or Alzheimer's care. This had the potential to affect all 94 current residents family members, and/ or guardians, and consumers.			Corrected			
	Findings include:						
	A review of the staf Is Alzheimer's, which providing care for re Alzheimer's was co	ch included tr esidents with	raining for all staff dementia and/or				
	During interview on service (SS)-A state and/ or Alzheimer's trained on dementia SS-A stated there v consumers, family either via written or training related to A	ed staff traini was for all s a care upon l vas no notifi members, ar electronic no	ing for dementia staff and they were hire and annually. cation provided to nd/ or guardians otification of staff				
	SUGGESTED MET facility could review dementia training a electronic means o	the Minnesond the	ota statutes for a written or				

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00010	B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PARK RI	VER ESTATES CARE	CENTER	CET STREE PIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	dementia training to could implement the admission process and implement an a quality assurance p compliance.	the consumer. The facility e communication into their The facility could then create auditing system as part of their	2 302			
2 830	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.		2 830			5/18/16
	by: Based on observati documentation revi that residents who s smoke safely, even friends, for 2 of 2 re Findings include:	ent is not met as evidenced on, interview, and ew the facility failed to ensure smoked had been assessed to with assistance of family and esidents (R13, R74).		Corrected		

Minnesota Department of Health

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Minnesota Department of Health

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI	E CONSTRUCTION	(X3) DATE	SLIBVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '			LETED
			A. BOILDING.			
		00010	B. WING		0.4/4	4/0046
		00010	D. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DARK DI	VER ESTATES CARE	CENTER 9899 AVO	CET STREE	T NORTHWEST		
FAIR III	VEN ESTATES CANE	COON RA	PIDS, MN 5	5433		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
0.000	Oznation and France in a	1	0.000			
2 830	•		2 830			
		ultiple sclerosis, hemiplegia				
		of half of the body), chronic				
		ary disease, peripheral				
	vascular disease, a					
		significant change Minimum				
		ted 1/15/16, indicated R13				
		ct and currently used tobacco.				
		sment (CAA) worksheet for , indicated R13 required total				
		or all mobility and cares.				
		ed 2/16 indicated R13				
	continued to smoke					
		3/16, at 1:08 p.m. with R13				
		ng materials were kept in a				
		to the wheelchair. R13 stated				
		3 outside to smoke. R13				
		neld the cigarette, lit the				
		e cigarette, and extinguished				
	the cigarette.					
	On 4/13/16, at 9:41	a.m. with nursing assistant				
		do not take R13 outside to				
	smoke. R13 only w	vent outside with the spouse to				
	smoke.					
		3 a.m. licensed practical nurse				
	` '	R13 did not have a smoking				
		B stated R13's spouse had the				
		er for R13 and the spouse				
	brought R13 outside					
		a.m. the director of nursing ents can smoke on the				
		be with family or a visitor to				
		to smoke. The DON stated				
	· ·	ole to keep the smoking				
		I stated there was no smoking				
		eted for R13. The DON stated				
		oking assessment in 2007,				
		e to locate it. Further the DON				
		idents are at the facility staff				
	was responsible for					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00010		B. WING		04/	14/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PARK R	IVER ESTATES CARE	CENTER		CET STREE PIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	R74's diagnoses list dated 3/16/16, inclupulmonary disease, weakness, and nicc admission Minimum 3/24/16, indicated Frequired extensive hygiene and dressine eating, and currentl Assessment (CAA) daily living (ADLs), required staff assisidue to impaired mointolerance. R74's dindicated R74 was and came to the facility would take her out not allowed to take RN-A stated there word to the facility would take her out not allowed to take RN-A stated there word allowed to take RN-A stated there word and sigarettes herself. For cigarettes and light kept her jacket in houring an observating an observating and plate located just outside facility. R74 reache jacket, removed a copack, took out a lighter mouth, and lit the cigarette while talkit to garette while talkit in the cigarette whi	ted on the Admission aded chronic obstruction lung cancer, muscle of the dependence. R7 in Data Set (MDS), data R74 was cognitively in assistance for personary, was independent by used tobacco. A Carworksheet for activitic dated 3/23/16, indicated and worksheet for activitic dated 3/23/16, indicated and activitic dated 3/23/16,	ve 4's ed tact, al with the Area es of ed R74 d ADLs y 6, moker." e (RN)-A amily amily aff was moke. as mentered the er tand	2 830			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
	00010	B. WING		04/1	4/2016	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
PARK RIVER ESTATES CARE	CENTER	OCET STREET APIDS, MN 55	NORTHWEST 6433			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
concrete. When R7 the cigarette to her extinguished by stel held it briefly to ens and disposed of it in the facility. During an interview RN-B stated resider can't smoke in the bear of the series o	ted the ashes onto the 4 was finished, she handed family member, which he pping on it, picked it up and ure it was no longer burning, in the trash by the entrance of on 4/13/16, at 9:40 a.m., into that smoke knew they building and family members eep the smoking materials. allowed to keep their smoking lity. RN-B stated an of been completed to ensure afely because, "We're not t." on 4/13/16, at 3:01 p.m., ker (LSW)-A stated she had seessment to ensure R74 because, "We don't offer g." LSW also stated, "It's not know of." on 4/13/16, at 3:08 p.m., R74 he attached transitional care tept her cigarettes at the since she was transferred to be has kept her package of ighter in her jacket pocket and the closet in her room. R74 he resident that often froom. The resident was bugh pockets of R74's draped over the chair. R74 would often take things from					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00010	B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 04/1	4/2010
PARK RI	VER ESTATES CARE	CENTER	CET STREE PIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	responsible for taking and they could keep their room. The DO in the facility that wand it was possible the smoking material responsible for every During a follow up in p.m., the DON verific completed for R74 safely. A facility smoking protection provided. SUGGESTED MET director of nursing of develop, review, an procedures to ensure assessments are condesigned could educate the policies and prodesigned could develop	or other visitors were ng the residents out to smoke, to their smoking materials in N stated there were residents andered into residents' rooms for them to have access to als and stated, "Yes, we are ryone's safety." Interview on 4/14/16, at 2:42 fied an assessment was not to ensure she could smoke Olicy was requested, but was THOD OF CORRECTION: The (DON) or designee could d/or revise policies and re resident smoking ompleted. The DON or rectate all appropriate staff on ocedures. The DON or rectop monitoring systems to	2 830			
21510	MN Rule 4658.1200 SpecializedRehabil	O Subp. 2 A.B. itative Services; Provision	21510			5/18/16
	rehabilitative servic resident's compreh nursing home must	of services. If specialized es are required in the ensive plan of care, the :: uired services; or obtain the				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00010	B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PARK RI	VER ESTATES CARE	CENTER	CET STREE PIDS, MN 5	T NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
21510	Continued From pa	ge 8	21510			
	required services from an outside source according to part 4658.0075.					
	This MN Requirements	ent is not met as evidenced				
	Based on interview facility failed to ensi Screening and Res	and document review, the ure a level II Preadmission ident Review (PASSRR) was resident (R2) who was lectual disabilities.		Corrected		
	Findings include:					
	indicated she had a 8/3/98 and had seve epilepsy and cerebro 9/1/15, indicated she function and though	cord face sheet dated 3/7/16, admitted to the facility on ere intellectual disability, ral palsy. R2's care plan he had impaired cognitive and processes related to severe cerebral palsy and dementia.				
	Screening For Persor Related Condition 7/1/98. Her propfacility was 8/3/98. Hennepin County a retardation, and her were such that she services. The Level person does require agency assures that have been specified	port Level II Preadmission cons with Mental Retardation in indicated R2 was evaluated cosed date of admission to this The Level II was completed by and indicated R2 had mental in medical and health needs required NF (nursing facility) I If further indicated "This is active treatment. The local at all active treatment needs in this person's individual II be met while this personing facility."				
	The Certified Facilit had authorization to	Admission Authorization To ty dated 8/3/98, indicated R2 admit to Park River Estates authorization indicated "No				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00010	B. WING		04/4	4/0046
		00010		TATE TIP CORE	04/1	4/2016
	PROVIDER OR SUPPLIER	9899 AVC	, ,	STATE, ZIP CODE T NORTHWEST		
PARK RI	VER ESTATES CARE	CENTER	APIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21510	Continued From pa	ge 9	21510			
	The above named in Hennepin county if warrant County involved further indicated He (developmentally diadmission and to complete the completed 7/1/98, with group home. LSW-A stated she to complete the	sabled) unit approved ontact them for paperwork. a.m. licensed social worker was not receiving active thought since she was in a did not need active treatment. Thought the Level II that was was when she was at the A stated she was not aware was completed indicating she				
	Hennepin county st completed 7/1/98 a	p.m. a DD supervisor from ated the last Level II was nd indicated that R2 should be atment according to the Level				
	director of nursing (review and revise p to ensuring PASAR residents. The DO system to educate s	THOD OF CORRECTION: The (DON) or designee could olicies and procedures related screenings are completed for N or designee could develop a staff and develop a monitoring esidents receive the required				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one				
21565	MN Rule 4658.1329 Medications Self Ac	5 Subp. 4 Administration of dmin	21565			5/18/16

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(3) DATE SURVEY COMPLETED		
		00010		B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
PARK RI	VER ESTATES CARE	CENTER		CET STREE	T NORTHWEST 5433		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CIENCIES DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 10		21565			
	Subp. 4. Self-adm self-administer med resident assessment care as required in 4658.0405 indicate is a written order from This MN Requirement by: Based on observation review, the facility for residents (R130) which cessation product (corder or assessment medications.	dications if the ent and comprese parts 4658.04 this practice is om the attendirent is not met on, interview, a cailed to identify no utilized a snum, and did	comprehensive hensive plan of 00 and safe and there ng physician. as evidenced and record 1 of 1 hoking not receive an		Corrected		
	Findings include:						
	R130's undated Adi multiple diagnoses sclerosis, chronic is diabetes, and deme quarterly Minimal D R130 had a BIMS of cognitive deficit. Ad R130 required exte personal cares. R13 12/29/15 indicated in	which included schemic heart of the entia. In review ata Set (MDS) of 8 indicating reditionally, the Nosive assistants and the entire e	I multiple disease, of the last , dated 3/18/16, noderate MDS identified ce with all MDS dated				
	A Self-Administration dated 12/21/15, ind self administer med self-administering in and R130 had no omedications.	icated R130 di lications, was i nedications pri	d not want to not or to admission,				
	R130's current care has impaired cognit processes d/t (due	tive function/ th	ought				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00010	B. WING		04/1	04/14/2016	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
PARK RI	VER ESTATES CARE	CENTER	APIDS, MN 5	T NORTHWEST 5433			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21565	Continued From pa	ge 11	21565				
	dementia. Resident	t has some forgetfulness."					
	Drugs (last reviewe chooses to self-adn interdisciplinary tea	entitled: Self Administration of d 4/15) directed "If a resident ninister drugs, the m must assess the resident's and visual abilities to carry out					
	observed chewing of was Nicorette, and in the top drawer of drawer was observed	12/16, at 9:03 a.m., R130 was gum. R130 stated the gum the Nicorette gum was stored his TV cabinet. The top ed to be open with two blister d inside. The cabinet was not					
	the dining room finis Nicorette gum was breast shirt pocket. observed coming do wheelchair, chewing	a.m., R130 was observed in shing breakfast. One piece of observed jutting out of his left Later at 9:44 a.m., R130 was own the hallway in his g a piece of gum. The piece of no longer in the left breast					
	R130 stated the Nichis wife and had nestated "staff must knever talked to him R130 could not statchewed in a day or the gum. During the Nicorette gum were table and 4.5 blister bottom of R130's di	view on 4/13/16, at 1:23 p.m., corette gum was brought in by ever told staff about it. R130 now" about the gum but had regarding use of the gum. the how many pieces he how often his wife supplied to interview, four pieces of the observed on R130's bedside in packs were observed in the rawer. Each piece of gum lligrams) of nicotine and a full ed 220 pieces.					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00010	B. WING		04/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PARK RI	VER ESTATES CARE	CENTER	CET STREE PIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 12	21565			
		on 4/14/16, at 10:05 a.m., d chewing on gum while				
	nurse (LPN)-A state couple of times che what kind of gum he resident had a med physician would have self-administere facility to be safe. T	2 a.m., licensed practical ed R130 was observed a swing gum, and did not know e chewed. LPN-A stated if a lication by the bedside, the we to order the medications to d and then assessed by the fire staff would then be form monthly checks on any safety.				
	stated R130 chewe	4/14/16, at 12:51 p.m., LPN-B d gum in the dining room, but requently he chewed gum or was.				
	(NA)-A stated chew R130 did after getti	p.m., nursing assistant ring gum was the first thing ng up in the morning. NA-A e type of gum R130 chewed.				
	(RN)-A was unaware gum, was unaware	5 p.m., registered nurse re of R130's use of Nicorette of his history of tobacco use, his use on the MDS.				
	director of nursing (been admitted with were there any order the previous facility dependence. The E would be considered the expectate to assess R130 for	4/14/16, at 1:30 p.m., the (DON) stated R130 had not orders for Nicorette gum nor ers or admission papers from indicating tobacco DON stated the Nicorette gum d a medication. The DON ion for staff would have been safety to administer ero the gum at the bedside.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00010		B. WING		04/1	4/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARK RI	VER ESTATES CARE	CENTER		CET STREE APIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21565	Continued From pa	ige 13		21565			
	The DON would no R130 what type of DON stated R130 I gum.	gum they wer	e chewing. The				
	Although multiple fainterview they were gum use, he openly and received staff addition, he travele Nicorette gum seer	unaware of F y stored the g assistance wit d throughout	R130's Nicorette um in his room th all cares. In the facility with				
	Nicorette gum seen hanging out of his pockets. In a follow-up interview on 4/18/16, at 2:54 p.m., R130's wife indicated he had been using Nicorette since admission to the facility. She supplied him with two boxes of gum a month, for a total of 440 pieces. R130's wife was not aware of how many pieces R130 chewed in a day stating it was "a lot." She believed the facility was aware of R130's gum use, but stated the facility had never assessed him to administer it.						
	Review of R130's physician orders, signed on 3/7/16, identified no orders for Nicorette gum nor did they address R130's ability to self-administer medications.						
	In review of the maproduct label read and pets," "Do not day," and directed abefore use if you have attack, or irre. The label also read and must be used a results."	'Keep out of ruse more that consumers to ave heart dular heartbe	reach of children in 24 pieces a "Ask a doctor lisease, recent ator diabetes." m is a medicine				
	SUGGESTED MET director of nursing dfevelop, review, a	(DON) or des	ignee could				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00010	B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PARK RI	VER ESTATES CARE	CENTER	CET STREE PIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X5) COMPLETE DATE	
21565	procedures to ensuself-administer their comprehensively as designee could edut the policies and prodesignee could devensure ongoing corrections.	re residents eho want to r medications are ssessed. The DON or scate allappropriate staff on scedures. The DON or relop monitoring systems to appliance.	21565			
21610	TIME PERIOD FOR CORRECTION: Twenty one (21) days MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area; Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.		21610			5/18/16
	by: Based on observati review, the facility for medications (stored for anybody in the foresident use, and not affect 45 of 45 resident use.	ent is not met as evidenced on, interview, and document ailed to ensure stock filled d medications that can used acility) were available for ot expired. This had potential esidents residing in the East he facility at the time of the		Corrected		
	Findings include:					
	dated 4/15, identified which they could re	ng Orders for Long Term Care ed orders for all residents in ceive an enema every three constipation, if resident had				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00010		B. WING		04/	14/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARK RI	VER ESTATES CARE	CENTER		CET STREE PIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21610	no results from sup During an observat room on 4/14/16, a practical nurse (LP) three boxes of unop enemas with an ex stated the enemas and were available expired and should further review, the ropened vial of Tube for tuberculosis) wit 2/21/16. LPN-C sta on 2/21/16, and wa skin tests for new re wings of the facility available for reside discarded after 30 of Further, LPN-C sta monitored the med medications were re On 4/14/16, at 2:45 stated the night nur through the medicat been assigned to g rooms to ensure m An undated facility Opened form was I	ion of the met 10:15 a.m. N)-C, a cupboened, stock piration date were on the for resident have been refrigerator of the a handwritted the solutted she was ication storage to the solution storage to the solution storage that the solution should be solved the solution should be solved the solutions with the solu	with licensed poard contained to ard contained to saline laxative of 8/15. LPN-C standing orders use, but were replaced. Upon contained an n (used for testing then date of ion was opened minister tuberculin the East and West ted the vial was hould of been gopened. To be a compared to one had ever the medication to the poor to one had ever the medication the emedication the contained the vial was hould of been gopened. To Date When Medication	21610			
	Administration Rec the East/West med identified the tubero discarded, "30 days A medication storage not provided.	ication cart. culin solution s after openii	The form should be ng."				
	SUGGESTED MET	HOD OF CO	ORRECTION: The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED		
				A. BUILDING.			
		00010		B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARK RI	VER ESTATES CARE	CENTER		CET STREE PIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 16		21610			
	director of nursing (develop systems to carts and rooms for DON or designee cand TMA's. The DO monitoring systems compliance.	ensure mor expired me ould educate NN or design to ensure o	nitoring of med dications. The e all licensed staff ee could develop ngoing				
	TIME PERIOD FOR (21) days.	RCORRECT	ION: Iwenty-one				
21665	MN Rule 4658.1400) Physical E	nvironment	21665			5/18/16
	A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.						
	This MN Requirements: Based on observation review, the facility for dining environment (Enhanced dining, this had the potention residents who ate in time of the survey.	on, interview ailed to provi for 2 of 3 dii Transitional (al to affect 3	v and document ide a homelike ning rooms Care Unit (TCU)) 7 out of 94		Corrected		
	Findings include:						
	During observation main dining room, or residents were sear with seating for four covered in aqua coand pepper shakers holder, utensils, emprotectors. The resident main protection of the company of the	on 4/12/16, a ted at severa r residents. I lored tablecles, a menu in upty plastic c	at 11:50 a.m., al square tables The tables were oths and held salt an upright plastic ups, and clothing				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00010	B. WING		04/1	4/2016
	PROVIDER OR SUPPLIER	CENTER 9899 AVC		TATE, ZIP CODE F NORTHWEST 5433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21665	style, with dietary at their lunch meal and of the residents for used to serve the reduring the lunch meal and the lunch meal and the glasses on in front of the resident the enhanced dining seating for four residents had clothing tables and placing the emilids stacked in the residents were eating. During interview 4/1 supervisor (DS)-A susing trays for the room a couple mond dining more homelificated the facility we all of the dining room been developed on Further, DS-A state the thermal plate countries and using them to supervisor on the plate of the dining them to supervisor the plate of the	ides serving beverages and d placed it on the table in front them to eat. No trays were esidents in this dining room eal in the main dining room. 4/12/16, at 12:00 p.m. in the six residents were observed ge table. Staff began to serve tic trays. Staff left the plates the tray and placed the meal ent. ion on 4/12/16, at 12:10 p.m. groom had six tables with dents at each table. The protectors at each resident's nanced dining room staff were neir meal on trays. Staff was a meal on the serving tray in the son the table. Staff was juice and milk for the residents pty containers in the thermal middle of each table where ng. 13/16, at 11:36 a.m. dietary stated the facility stopped meal service in the main dining the earlier in order to make ke for the residents. DS-A ould like to stop using trays in ms, however no plan had how to accomplish this. d staff should not be placing overs in front of the residents				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00010	B. WING		04/1	14/2016
	PROVIDER OR SUPPLIER	CENTER 9899 AVC		STATE, ZIP CODE ET NORTHWEST 55433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	residents served or they serve the food be nice if they would tables and remove more home like for A policy was request none was provided. SUGGESTED MET director of nursing (educate staff regard clean, and homelike DON or designee costaff to conduct per ensure a safe, cleat environment maintal	n trays, "I don't understand why on trays. I really think it would d just put the plates on the the trays. It would make it them."	21665			
21685	Subp. 2. Physical princluding walls, floor systems, and equip continuous state of with regard to the howell-being of the regroutine maintenance. This MN Requirements: Based on observation	Subp. 2 Plant eration, & Maintenance plant. The physical plant, rs, ceilings, all furnishings, ament must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program. ent is not met as evidenced on and interview, the facility afe and sanitary environment	21685	Corrected		5/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00010	B. WING		04/14/2016	
	PROVIDER OR SUPPLIER	CENTER 9899 AVO		STATE, ZIP CODE T NORTHWEST 5433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	was maintained for W126, W144) revie and 5 of 5 resident N134, W146) revier cracks, and walls in Findings include: On 4/13/16, at 11:0 completed with the and the following eridentified: CEILING TILES: Resident room W14 white suspended contified stains. MD measure five ceiling tiles which the ceiling tile measure five ceiling tile measure stained area that must a ceiling tile measure stained area that continued area that must a ceiling tile measure stained area that continued area that must are the continued area that must area that must are the continued area that must are the conti	3 of 3 resident rooms (W143, wed with ceiling tile damage, rooms (N135, N140, N133, wed with loose grab bars, a disrepair. 0 a.m. a facility tour was maintenance director (MD), nvironmental concerns were 43 was observed to have five eiling tiles which had brown ed the tiles and staining on the chidentified: sured 2' (feet) x (by) 4' with a a that measured 3" (inches) x sured 2' x 4' with a brown, easured 2.5" x 3". sured 2' x 4' with a brown, easured 4.5" x 2.5". sured 1' x 4' with a brown, easured 4" x 14". sured 1' x 4' with a brown, easured 4" x 14". sured 1' x 4' with a brown, easured 4" x 14". sured 1' x 4' with a brown, easured 4" x 14". sured 1' x 4' with a brown, easured 1' x 4	21685			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00010		B. WING		04/	14/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARK RI	VER ESTATES CARE	CENTER		CET STREE APIDS, MN 5	T NORTHWEST 5433		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21685	2: Ceiling tile meas stained area that co 24" x 42". MD stated bathroor problem as moistur tiles. MD further staplaced correctly in t stains were through them. W144 was observe suspended ceiling thad brown stains. Measured 2' x 4' wimeasured 4.5" x 9" may have become sconditioning sweath tile." GRAB BARS/ROOM N135 was observed grab bar located be In addition, an approbserved in the intention of the grab bar. MD agand there was a 3" bar between the sin that the grab bar located be MD stated the grab tighten it. N133 was observed grab bar located be MD stated the would not aware it was located be MD stated he would not aware	sured 24" x 42' by ered the ention tiles have "a e drips down a ted ceiling tile; he rails. MD ich the entire tile d to have one ile, near the cell of the by the stained from the stained from the stained from the gadding, "I we will be to have a look tween the sink oximate 3" craserior surface of greed the grab stress crack book and the toiled to have a look tween the sink bar was loosed to have a look tween the sink bar was loosed to have a look tween the sink bar was loosed to have a look tween the sink bar was loosed to have a look tween the sink dighten the grose."	lways" been a and stains the s should be lentified the on both of white eiling vent which ceiling tile ained area that he ceiling tile air vill replace this PAIR: se and wobbly and the toilet. ck was the wall behind bar was loose ehind the grab st. se and wobbly and the toilet. and he would see and wobbly and the toilet. and he would see and wobbly and the toilet. The wall behind the grab st.	21685			
	N134 was observed	d to have an ap	oproximate 3"				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00010		B. WING		04/	14/2016
NAME OF PROVIDER OR S	SUPPLIER				STATE, ZIP CODE		
PARK RIVER ESTATE	S CARE	CENTER		CET STREE PIDS, MN 5	T NORTHWEST 5433		
PREFIX (EACH D	EFICIENCY	TEMENT OF DEF 'MUST BE PREC SC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
the grab bar marks and MD stated bar, and he stated the sepatched W146 was marks and wall. Two a sheetrock, likely from several scuwall in this on the wall. On 4/13/16 preventative grab bars of should also grab bars a aware any were loose stated loos issue" and Further, MI stained and replaced. When interfacility admit policy on clibars for fur SUGGEST administrat director of liver stated bars for fur support of the state of the s	e interiorar. There gouges there was a would to scrapes a mand pair observe gouges areas on MD state are loose of the grant of the gran	r surface of the were also son the wall in a 3" crack ighten the grand gouges on the lower this wall also ed the wall when the well when the surface book on the lower this wheelch on the lower this wheelch on the lower this wall also ed the wall when the wall when the surface book on the lower than the well when the surface book on the lower than the well when the well be a.m. MD stenance book on the lower than the well be and the grab bars we hall be, "Tighthe observed ed and should on 4/13/16, and r stated the faceiling tiles of the colling tiles	ated he used a and checked the AD stated staff if they noticed srepair, "I was not boked at today m to me." MD	21685			

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A. BUILDING:	
00010 B. WING	04/14/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
PARK RIVER ESTATES CARE CENTER 9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
tiles, scuffed walls, loose bathroom transfer bars and other personal care equiprment are managed/repaired to maintain as safe, clean, homelike environment. The administrator or designee could educate all appropriate staff on the program, and could develop monitoring systmes to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	