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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: K490

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

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements

Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 06/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/03/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/15/2016
(L33)

Posted 08/03/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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.

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

MDH
Minnesota Department of Health

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245448 Y1	A. Building 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 F0252	Correction	ID Prefix F0323	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(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 F0431	Correction	ID Prefix F0465	Correction
Reg. # 483.45(a)	Completed	Reg. # 483.60(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 OF SURVEYOR	DATE
	BF/kfd	6/14/2016	10562	6/6/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245448	A. Building 01 - MAIN BUILDING 01 B. Wing	6/3/2016

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 Reg. # NFPA 101 LSC K0050	Correction Completed 05/18/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (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 SURVEY COMPLETED ON	
4/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245448	A. Building 02 - NEW WING B. Wing	6/3/2016

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 Reg. # NFPA 101 LSC K0050	Correction Completed 05/18/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (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 SURVEY COMPLETED ON 4/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K490

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00010

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **99** (L18)
13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NE II 05/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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.

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

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

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
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify 1 of 1 residents (R130) who utilized a smoking cessation product (gum), and did not receive an order or assessment for self administration of medications. Findings include: R130's undated Admission Record identified multiple diagnoses which included multiple sclerosis, chronic ischemic heart disease, diabetes, and dementia. In review of the last	F 176	The facility has modified the admission assessment in order to identify if smoking cessation products are being used. If cessation products are being used, a physicians order for self administration will be obtained and a self administration assessment will be completed. A physician order was received for R130 to use nicorette gum and a self administration assessment was completed. Based upon the assessment, R130 is not safe to self administer the gum. The gum was removed from R130's	5/18/16

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

Electronically Signed | 05/04/2016

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F 176	Continued From page 1 quarterly Minimal Data Set (MDS), dated 3/18/16, R130 had a BIMS of 8 indicating moderate cognitive deficit. Additionally, the MDS identified R130 required extensive assistance with all personal cares. R130's admission MDS dated 12/29/15 indicated he had no tobacco use. A Self-Administration of Medication Evaluation, dated 12/21/15, indicated R130 did not want to self administer medications, was not self-administering medications prior to admission, and R130 had no order to self-administer medications. R130's current care plan identified "The resident has impaired cognitive function/ thought processes d/t (due to) DX (diagnosis) of dementia. Resident has some forgetfulness." The facility's policy entitled: Self Administration of Drugs (last reviewed 4/15) directed "If a resident chooses to self-administer drugs, the interdisciplinary team must assess the resident's cognitive, physical, and visual abilities to carry out this responsibility." During interview 4/12/16, at 9:03 a.m., R130 was observed chewing gum. R130 stated the gum was Nicorette, and the Nicorette gum was stored in the top drawer of his TV cabinet. The top drawer was observed to be open with two blister packs of gum stored inside. The cabinet was not able to be locked. On 4/13/16, at 9:41 a.m., R130 was observed in the dining room finishing breakfast. One piece of Nicorette gum was observed jutting out of his left breast shirt pocket. Later at 9:44 a.m., R130 was observed coming down the hallway in his	F 176	room and is being administered by nursing staff. R130's wife was informed that all future cessation products must be given to the nursing staff. All current residents will be asked if they use smoking cessation products on or before their next quarterly care conference and quarterly there after. Nursing staff will be informed of the updated admission assessment. The DON and LSW will be responsible to monitor the resident responses at the care conferences and will initiate a self administration assessment if the resident is using cessation product(s)and desires self administration for compliance. The updated admission assessment will be presented at the next Quality Assurance and Performance Improvement meeting in July 2016	

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F 176	Continued From page 2	F 176		

wheelchair, chewing a piece of gum. The piece of Nicorette gum was no longer in the left breast pocket.

During further interview on 4/13/16, at 1:23 p.m., R130 stated the Nicorette gum was brought in by his wife and had never told staff about it. R130 stated "staff must know" about the gum but had never talked to him regarding use of the gum. R130 could not state how many pieces he chewed in a day or how often his wife supplied the gum. During the interview, four pieces of Nicorette gum were observed on R130's bedside table and 4.5 blister packs were observed in the bottom of R130's drawer. Each piece of gum contained 4 mg (milligrams) of nicotine and a full box of gum contained 220 pieces.

During observation on 4/14/16, at 10:05 a.m., R130 was observed chewing on gum while watching TV.

On 4/14/16, at 10:42 a.m., licensed practical nurse (LPN)-A stated R130 was observed a couple of times chewing gum, and did not know what kind of gum he chewed. LPN-A stated if a resident had a medication by the bedside, the physician would have to order the medications to be self-administered and then assessed by the facility to be safe. The staff would then be responsible to perform monthly checks on any resident to ensure safety.

During interview on 4/14/16, at 12:51 p.m., LPN-B stated R130 chewed gum in the dining room, but did not know how frequently he chewed gum or what kind of gum it was.

On 4/14/16, at 1:05 p.m., nursing assistant

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(NA)-A stated chewing gum was the first thing R130 did after getting up in the morning. NA-A was uncertain of the type of gum R130 chewed.

On 4/14/16, at 12:55 p.m., registered nurse (RN)-A was unaware of R130's use of Nicorette gum, was unaware of his history of tobacco use, and had not coded his use on the MDS.

During interview on 4/14/16, at 1:30 p.m., the director of nursing (DON) stated R130 had not been admitted with orders for Nicorette gum nor were there any orders or admission papers from the previous facility indicating tobacco dependence. The DON stated the Nicorette gum would be considered a medication. The DON stated the expectation for staff would have been to assess R130 for safety to administer medications and keep the gum at the bedside. The DON would not have expected staff to ask R130 what type of gum they were chewing. The DON stated R130 had never been seen chewing gum.

Although multiple facility staff indicated through interview they were unaware of R130's Nicorette gum use, he openly stored the gum in his room and received staff assistance with all cares. In addition, he traveled throughout 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

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F 176	Continued From page 4 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 manufacturer's instructions, the product label read "Keep out of reach of children and pets," "Do not use more than 24 pieces a day," and directed consumers to "Ask a doctor before use if you have ... heart disease, recent heart attack, or irregular heartbeat...or diabetes." The label also read "Nicotine gum is a medicine and must be used a certain way to get the best results."	F 176		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a homelike dining environment for 2 of 3 dining rooms (Enhanced dining, Transitional Care Unit (TCU)) this had the potential to affect 37 out of 94 residents who ate in the two dinning rooms at the time of the survey. Findings include:	F 252	The facility will fully eliminate the use of trays in the enhanced and transitional care unit dining rooms effective 5/5/16 thus providing a more homelike environment. All meal items will be removed from the trays and placed on the table. The new serving system will be audited by the Director Food Service twice weekly for one month for each meal to ensure accuracy an efficiency of service.	5/18/16

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F 252	Continued From page 5 During observation of the meal service in the main dining room, on 4/12/16, at 11:50 a.m., residents were seated at several square tables with seating for four residents. The tables were covered in aqua colored tablecloths and held salt and pepper shakers, a menu in an upright plastic holder, utensils, empty plastic cups, and clothing protectors. The residents were served restaurant style, with dietary aides serving beverages and their lunch meal and placed it on the table in front of the residents for them to eat. No trays were used to serve the residents in this dining room during the lunch meal in the main dining room. During observation 4/12/16, at 12:00 p.m. in the TCU dinning room six residents were observed to be sitting at a large table. Staff began to serve their meals on plastic trays. Staff left the plates and the glasses on the tray and placed the meal in front of the resident. During an observation on 4/12/16, at 12:10 p.m. the enhanced dining room had six tables with seating for four residents at each table. The tables had clothing protectors at each resident's table spot. The enhanced dining room staff were passing residents their meal on trays. Staff was leaving the resident meal on the serving tray in front of the residents on the table. Staff was opening cartons of juice and milk for the residents and placing the empty containers in the thermal lids stacked in the middle of each table where residents were eating. During interview 4/13/16, at 11:36 a.m. dietary supervisor (DS)-A stated the facility stopped using trays for the meal service in the main dining room a couple months earlier in order to make dining more homelike for the residents. DS-A	F 252	The Director Food Service will be responsible for ongoing compliance. The results of the audit will be presented at the next Quality Assurance and Performance Improvement meeting in July 2016.	

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F 252	Continued From page 6 stated the facility would like to stop using trays in all of the dining rooms, however no plan had been developed on how to accomplish this. Further, DS-A stated staff should not be placing the thermal plate covers in front of the residents and using them to store garbage. During interview on 4/13/16, an anonymous family member stated they did not like seeing the residents served on trays, "I don't understand why they serve the food on trays. I really think it would be nice if they would just put the plates on the tables and remove the trays. It would make it more home like for them." A policy was requested on home like dinning but none was provided.	F 252		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to ensure that residents who smoked had been assessed to smoke safely, even with assistance of family and friends, for 2 of 2 residents (R13, R74). Findings include:	F 323	The facility has developed a new resident smoking policy which includes performing a smoking assessment of current residents and quarterly thereafter, smoking is confined to the area outside designated for smoking and that a resident's family or friend must	5/18/16

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F 323	Continued From page 7 R13's diagnoses from the undated Admission Record included multiple sclerosis, hemiplegia (complete paralysis of half of the body), chronic obstructive pulmonary disease, peripheral vascular disease, and neuromuscular dysfunction. R13's significant change Minimum Data Set (MDS) dated 1/15/16, indicated R13 was cognitively intact and currently used tobacco. A Care Area Assessment (CAA) worksheet for Falls dated 1/15/16, indicated R13 required total staff performance for all mobility and cares. R13's care plan dated 2/16 indicated R13 continued to smoke. An interview on 4/13/16, at 1:08 p.m. with R13 revealed the smoking materials were kept in a red pouch attached to the wheelchair. R13 stated the spouse took R13 outside to smoke. R13 stated the spouse held the cigarette, lit the cigarette, ashed the cigarette, and extinguished the cigarette. On 4/13/16, at 9:41 a.m. with nursing assistant (NA)-B stated staff do not take R13 outside to smoke. R13 only went outside with the spouse to smoke. On 4/13/16, at 11:53 a.m. licensed practical nurse (LPN)-B indicated R13 did not have a smoking assessment. LPN-B stated R13's spouse had the cigarettes and lighter for R13 and the spouse brought R13 outside to smoke. On 4/14/16, at 8:58 a.m. the director of nursing (DON) stated residents can smoke on the campus but have to be with family or a visitor to bring them outside to smoke. The DON stated the residents are able to keep the smoking materials. The DON stated there was no smoking assessment completed for R13. The DON stated R13 did have a smoking assessment in 2007, however was unable to locate it. Further the DON	F 323	accompany the resident to the outside designated area. The smoking assessment was updated to assess the residents' ability to smoke safely including to have the resident acknowledge that Park River Estates Care Center is a smoke-free building. R13 & R74 will be assessed to smoke safely and quarterly thereafter. Both residents will be given a copy of the new smoking policy. The new smoking policy will be included in the admission packet. Effective 5/12/16, no lighters, matches, e-cigs or tobacco products are allowed to be stored on the facility premises with the exception of R13 & R74 who are grandfathered in and who will have the option of keeping their smoking supplies in a locked medication room. A sign indicating "Designated Smoking Area" has been ordered and will be placed in the all ready established designated area located approximately 75 feet west of the main entrance. The new smoking policy and updated assessment will be reviewed with all nursing and social service staff. The LSW is responsible for ongoing compliance including reviewing the policy with R13 & R74 at their quarterly care conferences. The LSW & DON will present the new policy and updated assessment at the next Quality Assurance and Performance Improvement meeting in July 2016.	

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stated while the residents are at the facility staff was responsible for them.
A smoking policy was asked for and but not provided.
R74's diagnoses listed on the Admission Record, dated 3/16/16, included chronic obstructive pulmonary disease, lung cancer, muscle weakness, and nicotine dependence. R74's admission Minimum Data Set (MDS), dated 3/24/16, indicated R74 was cognitively intact, required extensive assistance for personal hygiene and dressing, was independent with eating, and currently used tobacco. A Care Area Assessment (CAA) worksheet for activities of daily living (ADLs), dated 3/23/16, indicated R74 required staff assistance with mobility and ADLs due to impaired mobility, pain, and activity intolerance. R74's care plan dated 4/12/16, indicated R74 was a "Current cigarette smoker."

On 4/12/16, at 9:08 a.m., registered nurse (RN)-A stated R74 smoked cigarettes, and her family came to the facility at least once a day. Family would take her out to smoke because staff was not allowed to take residents outside to smoke. RN-A stated there was no smoking assessment completed for R74 because she was, "Alert and oriented. She's with the program."
During an interview on 4/12/16, at 2:44 p.m., R74 stated she was only allowed to smoke when her family visited and she could light and hold the cigarettes herself. R74 stated she kept her cigarettes and lighter in her jacket pocket, and kept her jacket in her room.
During an observation on 4/12/16, at 2:54 p.m., R74's family member pushed her outside in the wheelchair, and placed her beside a bench located just outside of the front entrance of the facility. R74 reached into the right pocket of her

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jacket, removed a cigarette from the cigarette pack, took out a lighter, placed the cigarette in her mouth, and lit the cigarette. R74 smoked the cigarette while talking with her family member and occasionally reached her left hand beside the wheelchair and flicked the ashes onto the concrete. When R74 was finished, she handed the cigarette to her family member, which he extinguished by stepping on it, picked it up and held it briefly to ensure it was no longer burning, and disposed of it in the trash by the entrance of the facility.

During an interview on 4/13/16, at 9:40 a.m., RN-B stated residents that smoke knew they can't smoke in the building and family members were expected to keep the smoking materials. Residents were not allowed to keep their smoking materials in the facility. RN-B stated an assessment had not been completed to ensure R74 could smoke safely because, "We're not involved at all with it."

During an interview on 4/13/16, at 3:01 p.m., licensed social worker (LSW)-A stated she had not completed an assessment to ensure R74 could smoke safely because, "We don't offer supervised smoking." LSW also stated, "It's not part of my job that I know of."

During an interview on 4/13/16, at 3:08 p.m., R74 stated the staff on the attached transitional care unit (TCU) always kept her cigarettes at the nurse's station, but since she was transferred to her current room she has kept her package of cigarettes and her lighter in her jacket pocket and kept her jacket in the closet in her room. R74 stated there was one resident that often wandered into her room. The resident was observed going through pockets of R74's bathrobe that was draped over the chair. R74 stated the resident would often take things from

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F 323	Continued From page 10 other resident's room. During an interview on 4/14/16, at 8:59 a.m., the DON stated, "We don't do an assessment [for residents that smoke]. If they are alert and oriented, we kind of go off their cognition." The DON stated family or other visitors were responsible for taking the residents out to smoke, and they could keep their smoking materials in their room. The DON stated there were residents in the facility that wandered into residents' rooms and it was possible for them to have access to the smoking materials and stated, "Yes, we are responsible for everyone's safety." During a follow up interview on 4/14/16, at 2:42 p.m., the DON verified an assessment was not completed for R74 to ensure she could smoke safely. A facility smoking policy was requested, but was not provided.	F 323		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced	F 406		5/18/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 11 by: Based on interview and document review, the facility failed to ensure a level II Preadmission Screening and Resident Review (PASSRR) was followed for 1 of 1 resident (R2) who was assessed with intellectual disabilities. Findings include: R2's Admission Record face sheet dated 3/7/16, indicated she had admitted to the facility on 8/3/98 and had severe intellectual disability, epilepsy and cerebral palsy. R2's care plan 9/1/15, indicated she had impaired cognitive function and thought processes related to severe mental retardation, cerebral palsy and dementia. R2's Evaluative Report Level II Preadmission Screening For Persons with Mental Retardation or Related Conditions indicated R2 was evaluated on 7/1/98. Her proposed date of admission to this facility was 8/3/98. The Level II was completed by Hennepin County and indicated R2 had mental retardation, and her medical and health needs were such that she required NF (nursing facility) services. The Level II further indicated "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." A County Of Anoka Admission Authorization To The Certified Facility dated 8/3/98, indicated R2 had authorization to admit to Park River Estates Care Center. The Authorization indicated "No Further Anoka County involvement is anticipated. The above named facility is requested to notify Hennepin county if circumstances in this case	F 406	The facility does ensure that a PASRR is completed and reviews the results prior to the resident being accepted for admission. Hennepin County was contacted regarding the documented need for a level II screening for R2. Hennepin County contacted R2's conservator and informed our LSW on April 29, 2016 that she "Completed the attempt of screening by phone-it is his right to decline it. I will be submitting the paperwork soon." The results from Hennepin County will be documented in R2's medical record after receipt. There are no other current residents that require a level II screening or treatment. The LSW is responsible to monitor that all PASRR's are completed prior to admission. The LSW will work with the county if a possible admission requires a level II screening & treatment. If R2's screening results in active treatment, the LSW will also monitor to make sure R2 receives active treatment as long as it is required. The report from Hennepin County will be reviewed at the next Quality Assurance and Performance Improvement meeting in July 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. BUILDING _____ B. WING _____	04/14/2016

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F 406	Continued From page 12 warrant County involvement." The authorization further indicated Hennepin County DD (developmentally disabled) unit approved admission and to contact them for paperwork. On 4/14/16, at 9:22 a.m. licensed social worker (LSW)-A stated R2 was not receiving active treatment and she thought since she was in a nursing home she did not need active treatment. LSW-A stated she thought the Level II that was completed 7/1/98, was when she was at the group home. LSW-A stated she was not aware that another level II was completed indicating she no longer needed active treatment. On 4/15/16, at 3:00 p.m. a DD supervisor from Hennepin county stated the last Level II was completed 7/1/98 and indicated that R2 should be receiving active treatment according to the Level II.	F 406		
F 431 SS=B	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		5/18/16

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F 431	Continued From page 13 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure stock filled medications (stored medications that can used for anybody in the facility) were available for resident use, and not expired. This had potential to affect 45 of 45 residents residing in the East and West units of the facility at the time of the survey. Findings include: The facility's Standing Orders for Long Term Care dated 4/15, identified orders for all residents in which they could receive an enema every three days as needed for constipation, if resident had no results from suppository. During an observation of the medication storage	F 431	The facility updated the system to monitor for expired medications including those stored in the medication rooms and refrigerators. The night shift nurse had been designated to check weekly for expiration dates on all medications in the medication room and refrigerator. As a guideline, medications that will expire in 1-10 days may be disposed of properly. The DON will review the updated monitoring system with the nurses. The DON will audit one medication room and refrigerator each week for three weeks to assure compliance and the results will be presented at the next Quality Assurance and Performance Improvement meeting in July 2016. The DON is responsible for ongoing compliance.	

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F 431	Continued From page 14 room on 4/14/16, at 10:15 a.m. with licensed practical nurse (LPN)-C, a cupboard contained three boxes of unopened, stock, saline laxative enemas with an expiration date of 8/15. LPN-C stated the enemas were on the standing orders and were available for resident use, but were expired and should have been replaced. Upon further review, the refrigerator contained an opened vial of Tuberculin protein (used for testing for tuberculosis) with a handwritten date of 2/21/16. LPN-C stated the solution was opened on 2/21/16, and was used to administer tuberculin skin tests for new residents on the East and West wings of the facility. LPN-C stated the vial was available for resident use, but should of been discarded after 30 days of being opened. Further, LPN-C stated she was not sure who monitored the medication storage room to ensure medications were not expired. On 4/14/16, at 2:45 p.m., the director of nursing stated the night nurses were responsible to go through the medication carts, but no one had ever been assigned to go through the medication rooms to ensure medications were not expired. An undated facility Medications To Date When Opened form was located in a Medication Administration Record (MAR) binder located on the East/West medication cart. The form identified the tuberculin solution should be discarded, "30 days after opening." A medication storage policy was requested but not provided.	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		5/18/16

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F 465	Continued From page 15 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe and sanitary environment was maintained for 3 of 3 resident rooms (W143, W126, W144) reviewed with ceiling tile damage, and 5 of 5 resident rooms (N135, N140, N133, N134, W146) reviewed with loose grab bars, cracks, and walls in disrepair. Findings include: On 4/13/16, at 11:00 a.m. a facility tour was completed with the maintenance director (MD), and the following environmental concerns were identified: CEILING TILES: Resident room W143 was observed to have five white suspended ceiling tiles which had brown stains. MD measured the tiles and staining on the five ceiling tiles which identified: 1: Ceiling tile measured 2' (feet) x (by) 4' with a brown, stained area that measured 3" (inches) x 7". 2: Ceiling tile measured 2' x 4' with a brown, stained area that measured 2.5" x 3". 3: Ceiling tile measured 2' x 4' with a brown, stained area that measured 2.5" x 2.5". 4: Ceiling tile measured 1' x 4' with a brown, stained area that measured 4" x 14". 5: Ceiling tile measured 1' x 4' with a brown,	F 465	The facility has developed a resident room checklist that includes checking the condition of walls, ceilings, floors, grab bars and more areas. Those items in need of repair/attention will be completed by the Maintenance Department. The checklist will be completed for all resident rooms each quarter. The checklist was utilized for resident rooms N135, N140, N133, N134 and W146, and all repairs will be made. The checklist, once completed, is signed and dated by the maintenance department and forwarded to the administrator for his signature. The Director of Maintenance is responsible for ongoing compliance. The new checklist along with completed checklists for resident rooms N135, N140, N133, N134 and W146 will be presented at the next Quality Assurance and Performance Improvement meeting in July 2016	

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F 465	Continued From page 16 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. W144 was observed to have one white suspended ceiling tile, near the ceiling vent which had brown stains. MD stated the ceiling tile measured 2' x 4' with a brown, stained area that measured 4.5" x 9". MD stated the ceiling tile may have become stained from the air conditioning sweating adding, "I will replace this tile." GRAB BARS/ROOMS IN DISREPAIR: N135 was observed to have a loose and wobbly grab bar located between the sink and the toilet. In addition, an approximate 3" crack was observed in the interior surface of the wall behind the grab bar. MD agreed the grab bar was loose and there was a 3" stress crack behind the grab bar between the sink and the toilet.	F 465		

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F 465	Continued From page 17 N140 was observed to have a loose and wobbly grab bar located between the sink and the toilet. MD stated the grab bar was loose, and he would tighten it. N133 was observed to have a loose and wobbly grab bar located between the sink and the toilet. MD stated he would tighten the grab bar, "I was not aware it was loose." N134 was observed to have an approximate 3" crack on the interior surface of the the wall behind the grab bar. There were also several black scuff marks and gouges on the wall in the bathroom. MD stated there was a 3" crack behind the grab bar, and he would tighten the grab bar. MD also stated the scrapes and gouges on the wall should be patched and painted, "It is pretty scuffed up." W146 was observed to have several black scuff marks and gouges on the lower portion of the wall. Two areas on this wall also had exposed sheetrock. MD stated the wall was in disrepair likely from the resident's wheelchair; there were several scuff marks on the lower portion of the wall in this room. Further, MD stated the scuffing on the wall measured 2' x 7' in size. On 4/13/16, at 11:48 a.m. MD stated he used a preventative maintenance book and checked the grab bars on a monthly basis. MD stated staff should also be letting him know if they noticed grab bars are loosening or in disrepair, "I was not aware any of the grab bars we looked at today were loose until you showed them to me." MD stated loose fitting grab bars were a, "Safety issue" and they should be, "Tight and secure." Further, MD stated the observed ceiling tiles were	F 465		

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F 465	Continued From page 18 stained and damaged and should have been replaced. When interviewed on 4/13/16, at 1:08 p.m. the facility administrator stated the facility had no policy on checking ceiling tiles or checking grab bars for function.	F 465		

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	245448	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/14/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on April 14, 2016. At the time of this survey, Park River Estates Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us,and	K 000	EPOC	

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.

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Park River Estates Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1988, an addition was constructed to the South Wing that was determined to be of Type II(111) construction. Another addition was added in 1992 to the East Wing and was determined to be of Type II(111). Because the original building and the 2 additions can be lowered to the lowest construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a)is NOT MET as evidenced by:	K 000		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		5/18/16

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K 050 SS=D	Continued From page 2 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying.conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility did not conduct fire drills under varying times. This could affect the staff response to evacuate all residents in the event of a fire or an emergency in accordance with LSC(00) section 19.7.1.2. Findings include: On facility tour between the hours of 12:30 PM and 3:30 PM on 4/14/2016, during documentation review it was revealed that the facility conducted Day-shift fire drills between the hours of 10:23 AM, 10:15 AM, 10:10 AM, 10:10 AM not varied times as required. This deficient practice was verified by the Administrator at the time of the inspection.	K 050	The facility will conduct fire drills at varying times at least quarterly on each shift. A schedule has been developed with varied times with at least 1.5 hours in between the previously scheduled drill. The facility did conduct a fire drill on April 25, 2016 at 7:30 am. The director of maintenance is responsible for monitoring compliance for varied times. The schedule will be reviewed at the July 2016 Quality Assurance and Performance Improvement (QAPI) meeting.	

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This wing onto Park River Estates was constructed in 2011. It is a one story building with no basement. The construction type is determined to be type II(111). The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire doors. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility is licensed for 99 beds with a census of 91 at the time of inspection. The requirement at 42 CFR, Subpart 483.70(a)is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected	K 050		5/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. BUILDING **02 - NEW WING** B. WING _____	**04/14/2016**

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K 050	Continued From page 2 times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility did not conduct fire drills under varying times. This could affect the staff response to evacuate all residents in the event of a fire or an emergency in accordance with LSC(00) section 18.7.1.2. Findings include: On facility tour between the hours of 12:30 PM and 3:30 PM on 4/14/2016, during documentation review it was revealed that the facility conducted Day-shift fire drills between the hours of 10:23 AM, 10:15 AM, 10:10 AM, 10:10 AM not varied times as required. This deficient practice was verified by the Administrator at the time of the inspection.	K 050	The facility will conduct fire drills at varying times at least quarterly on each shift. A schedule has been developed with varied times with at least 1.5 hours in between the previously scheduled drill. The facility did conduct a fire drill on April 25, 2016 at 7:30 am. The director of maintenance is responsible for monitoring compliance for varied times. The schedule will be reviewed at the July 2016 Quality Assurance and Performance Improvement (QAPI) meeting.	

Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/11/16 through 4/14/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills.	2 302		5/18/16

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2 302	Continued From page 2 (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. 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. Findings include: A review of the staff training program titled What Is Alzheimer's, which included training for all staff providing care for residents with dementia and/ or Alzheimer's was completed by all staff.. During interview on 4/13/16, at 11:00 a.m. social service (SS)-A stated staff training for dementia and/ or Alzheimer's was for all staff and they were trained on dementia care upon hire and annually. SS-A stated there was no notification provided to consumers, family members, and/ or guardians either via written or electronic notification of staff training related to Alzheimer's or dementia care. SUGGESTED METHOD OF CORRECTION: The facility could review the Minnesota statutes for dementia training and develop a written or electronic means of communication for the	2 302	Corrected	

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2 302	Continued From page 3 dementia training to the consumer. The facility could implement the communication into their admission process. The facility could then create and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to ensure that residents who smoked had been assessed to smoke safely, even with assistance of family and friends, for 2 of 2 residents (R13, R74). Findings include: R13's diagnoses from the undated Admission	2 830	Corrected	5/18/16

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2 830	Continued From page 4 Record included multiple sclerosis, hemiplegia (complete paralysis of half of the body), chronic obstructive pulmonary disease, peripheral vascular disease, and neuromuscular dysfunction. R13's significant change Minimum Data Set (MDS) dated 1/15/16, indicated R13 was cognitively intact and currently used tobacco. A Care Area Assessment (CAA) worksheet for Falls dated 1/15/16, indicated R13 required total staff performance for all mobility and cares. R13's care plan dated 2/16 indicated R13 continued to smoke. An interview on 4/13/16, at 1:08 p.m. with R13 revealed the smoking materials were kept in a red pouch attached to the wheelchair. R13 stated the spouse took R13 outside to smoke. R13 stated the spouse held the cigarette, lit the cigarette, ashed the cigarette, and extinguished the cigarette. On 4/13/16, at 9:41 a.m. with nursing assistant (NA)-B stated staff do not take R13 outside to smoke. R13 only went outside with the spouse to smoke. On 4/13/16, at 11:53 a.m. licensed practical nurse (LPN)-B indicated R13 did not have a smoking assessment. LPN-B stated R13's spouse had the cigarettes and lighter for R13 and the spouse brought R13 outside to smoke. On 4/14/16, at 8:58 a.m. the director of nursing (DON) stated residents can smoke on the campus but have to be with family or a visitor to bring them outside to smoke. The DON stated the residents are able to keep the smoking materials. The DON stated there was no smoking assessment completed for R13. The DON stated R13 did have a smoking assessment in 2007, however was unable to locate it. Further the DON stated while the residents are at the facility staff was responsible for them.	2 830		

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2 830	Continued From page 5 R74's diagnoses listed on the Admission Record, dated 3/16/16, included chronic obstructive pulmonary disease, lung cancer, muscle weakness, and nicotine dependence. R74's admission Minimum Data Set (MDS), dated 3/24/16, indicated R74 was cognitively intact, required extensive assistance for personal hygiene and dressing, was independent with eating, and currently used tobacco. A Care Area Assessment (CAA) worksheet for activities of daily living (ADLs), dated 3/23/16, indicated R74 required staff assistance with mobility and ADLs due to impaired mobility, pain, and activity intolerance. R74's care plan dated 4/12/16, indicated R74 was a "Current cigarette smoker." On 4/12/16, at 9:08 a.m., registered nurse (RN)-A stated R74 smoked cigarettes, and her family came to the facility at least once a day. Family would take her out to smoke because staff was not allowed to take residents outside to smoke. RN-A stated there was no smoking assessment completed for R74 because she was, "Alert and oriented. She's with the program." During an interview on 4/12/16, at 2:44 p.m., R74 stated she was only allowed to smoke when her family visited and she could light and hold the cigarettes herself. R74 stated she kept her cigarettes and lighter in her jacket pocket, and kept her jacket in her room. During an observation on 4/12/16, at 2:54 p.m., R74's family member pushed her outside in the wheelchair, and placed her beside a bench located just outside of the front entrance of the facility. R74 reached into the right pocket of her jacket, removed a cigarette from the cigarette pack, took out a lighter, placed the cigarette in her mouth, and lit the cigarette. R74 smoked the cigarette while talking with her family member and occasionally reached her left hand beside the	2 830		

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2 830	Continued From page 6 wheelchair and flicked the ashes onto the concrete. When R74 was finished, she handed the cigarette to her family member, which he extinguished by stepping on it, picked it up and held it briefly to ensure it was no longer burning, and disposed of it in the trash by the entrance of the facility. During an interview on 4/13/16, at 9:40 a.m., RN-B stated residents that smoke knew they can't smoke in the building and family members were expected to keep the smoking materials. Residents were not allowed to keep their smoking materials in the facility. RN-B stated an assessment had not been completed to ensure R74 could smoke safely because, "We're not involved at all with it." During an interview on 4/13/16, at 3:01 p.m., licensed social worker (LSW)-A stated she had not completed an assessment to ensure R74 could smoke safely because, "We don't offer supervised smoking." LSW also stated, "It's not part of my job that I know of." During an interview on 4/13/16, at 3:08 p.m., R74 stated the staff on the attached transitional care unit (TCU) always kept her cigarettes at the nurse's station, but since she was transferred to her current room she has kept her package of cigarettes and her lighter in her jacket pocket and kept her jacket in the closet in her room. R74 stated there was one resident that often wandered into her room. The resident was observed going through pockets of R74's bathrobe that was draped over the chair. R74 stated the resident would often take things from other resident's room. During an interview on 4/14/16, at 8:59 a.m., the DON stated, "We don't do an assessment [for residents that smoke]. If they are alert and oriented, we kind of go off their cognition." The	2 830		

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2 830	Continued From page 7 DON stated family or other visitors were responsible for taking the residents out to smoke, and they could keep their smoking materials in their room. The DON stated there were residents in the facility that wandered into residents' rooms and it was possible for them to have access to the smoking materials and stated, "Yes, we are responsible for everyone's safety." During a follow up interview on 4/14/16, at 2:42 p.m., the DON verified an assessment was not completed for R74 to ensure she could smoke safely. A facility smoking policy was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident smoking assessments are completed. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the	21510		5/18/16

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21510	Continued From page 8 required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a level II Preadmission Screening and Resident Review (PASSRR) was followed for 1 of 1 resident (R2) who was assessed with intellectual disabilities. Findings include: R2's Admission Record face sheet dated 3/7/16, indicated she had admitted to the facility on 8/3/98 and had severe intellectual disability, epilepsy and cerebral palsy. R2's care plan 9/1/15, indicated she had impaired cognitive function and thought processes related to severe mental retardation, cerebral palsy and dementia. R2's Evaluative Report Level II Preadmission Screening For Persons with Mental Retardation or Related Conditions indicated R2 was evaluated on 7/1/98. Her proposed date of admission to this facility was 8/3/98. The Level II was completed by Hennepin County and indicated R2 had mental retardation, and her medical and health needs were such that she required NF (nursing facility) services. The Level II further indicated "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." A County Of Anoka Admission Authorization To The Certified Facility dated 8/3/98, indicated R2 had authorization to admit to Park River Estates Care Center. The Authorization indicated "No	21510	Corrected	

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21510	Continued From page 9 Further Anoka County involvement is anticipated. The above named facility is requested to notify Hennepin county if circumstances in this case warrant County involvement." The authorization further indicated Hennepin County DD (developmentally disabled) unit approved admission and to contact them for paperwork. On 4/14/16, at 9:22 a.m. licensed social worker (LSW)-A stated R2 was not receiving active treatment and she thought since she was in a nursing home she did not need active treatment. LSW-A stated she thought the Level II that was completed 7/1/98, was when she was at the group home. LSW-A stated she was not aware that another level II was completed indicating she no longer needed active treatment. On 4/15/16, at 3:00 p.m. a DD supervisor from Hennepin county stated the last Level II was completed 7/1/98 and indicated that R2 should be receiving active treatment according to the Level II. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring PASAR screenings are completed for residents. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure residents receive the required screenings. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21510		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		5/18/16

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

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21565	Continued From page 10 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify 1 of 1 residents (R130) who utilized a smoking cessation product (gum), and did not receive an order or assessment for self administration of medications. Findings include: R130's undated Admission Record identified multiple diagnoses which included multiple sclerosis, chronic ischemic heart disease, diabetes, and dementia. In review of the last quarterly Minimal Data Set (MDS), dated 3/18/16, R130 had a BIMS of 8 indicating moderate cognitive deficit. Additionally, the MDS identified R130 required extensive assistance with all personal cares. R130's admission MDS dated 12/29/15 indicated he had no tobacco use. A Self-Administration of Medication Evaluation, dated 12/21/15, indicated R130 did not want to self administer medications, was not self-administering medications prior to admission, and R130 had no order to self-administer medications. R130's current care plan identified "The resident has impaired cognitive function/ thought processes d/t (due to) DX (diagnosis) of	21565	Corrected	

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21565	Continued From page 11 dementia. Resident has some forgetfulness." The facility's policy entitled: Self Administration of Drugs (last reviewed 4/15) directed "If a resident chooses to self-administer drugs, the interdisciplinary team must assess the resident's cognitive, physical, and visual abilities to carry out this responsibility." During interview 4/12/16, at 9:03 a.m., R130 was observed chewing gum. R130 stated the gum was Nicorette, and the Nicorette gum was stored in the top drawer of his TV cabinet. The top drawer was observed to be open with two blister packs of gum stored inside. The cabinet was not able to be locked. On 4/13/16, at 9:41 a.m., R130 was observed in the dining room finishing breakfast. One piece of Nicorette gum was observed jutting out of his left breast shirt pocket. Later at 9:44 a.m., R130 was observed coming down the hallway in his wheelchair, chewing a piece of gum. The piece of Nicorette gum was no longer in the left breast pocket. During further interview on 4/13/16, at 1:23 p.m., R130 stated the Nicorette gum was brought in by his wife and had never told staff about it. R130 stated "staff must know" about the gum but had never talked to him regarding use of the gum. R130 could not state how many pieces he chewed in a day or how often his wife supplied the gum. During the interview, four pieces of Nicorette gum were observed on R130's bedside table and 4.5 blister packs were observed in the bottom of R130's drawer. Each piece of gum contained 4 mg (milligrams) of nicotine and a full box of gum contained 220 pieces.	21565		

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21565	Continued From page 12 During observation on 4/14/16, at 10:05 a.m., R130 was observed chewing on gum while watching TV. On 4/14/16, at 10:42 a.m., licensed practical nurse (LPN)-A stated R130 was observed a couple of times chewing gum, and did not know what kind of gum he chewed. LPN-A stated if a resident had a medication by the bedside, the physician would have to order the medications to be self-administered and then assessed by the facility to be safe. The staff would then be responsible to perform monthly checks on any resident to ensure safety. During interview on 4/14/16, at 12:51 p.m., LPN-B stated R130 chewed gum in the dining room, but did not know how frequently he chewed gum or what kind of gum it was. On 4/14/16, at 1:05 p.m., nursing assistant (NA)-A stated chewing gum was the first thing R130 did after getting up in the morning. NA-A was uncertain of the type of gum R130 chewed. On 4/14/16, at 12:55 p.m., registered nurse (RN)-A was unaware of R130's use of Nicorette gum, was unaware of his history of tobacco use, and had not coded his use on the MDS. During interview on 4/14/16, at 1:30 p.m., the director of nursing (DON) stated R130 had not been admitted with orders for Nicorette gum nor were there any orders or admission papers from the previous facility indicating tobacco dependence. The DON stated the Nicorette gum would be considered a medication. The DON stated the expectation for staff would have been to assess R130 for safety to administer medications and keep the gum at the bedside.	21565		

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21565	Continued From page 13 The DON would not have expected staff to ask R130 what type of gum they were chewing. The DON stated R130 had never been seen chewing gum. Although multiple facility staff indicated through interview they were unaware of R130's Nicorette gum use, he openly stored the gum in his room and received staff assistance with all cares. In addition, he traveled throughout 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 manufacturer's instructions, the product label read "Keep out of reach of children and pets," "Do not use more than 24 pieces a day," and directed consumers to "Ask a doctor before use if you have ... heart disease, recent heart attack, or irregular heartbeat...or diabetes." The label also read "Nicotine gum is a medicine and must be used a certain way to get the best results." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could dfevelop, review, and/or revise policies and	21565		

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21565	Continued From page 14 procedures to ensure residents eho want to self-administer their medications are comprehensively assessed. The DON or designee could educate allappropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21565		
21610	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure stock filled medications (stored medications that can used for anybody in the facility) were available for resident use, and not expired. This had potential to affect 45 of 45 residents residing in the East and West units of the facility at the time of the survey. Findings include: The facility's Standing Orders for Long Term Care dated 4/15, identified orders for all residents in which they could receive an enema every three days as needed for constipation, if resident had	21610	Corrected	5/18/16

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21610	Continued From page 15 no results from suppository. During an observation of the medication storage room on 4/14/16, at 10:15 a.m. with licensed practical nurse (LPN)-C, a cupboard contained three boxes of unopened, stock, saline laxative enemas with an expiration date of 8/15. LPN-C stated the enemas were on the standing orders and were available for resident use, but were expired and should have been replaced. Upon further review, the refrigerator contained an opened vial of Tuberculin protein (used for testing for tuberculosis) with a handwritten date of 2/21/16. LPN-C stated the solution was opened on 2/21/16, and was used to administer tuberculin skin tests for new residents on the East and West wings of the facility. LPN-C stated the vial was available for resident use, but should of been discarded after 30 days of being opened. Further, LPN-C stated she was not sure who monitored the medication storage room to ensure medications were not expired. On 4/14/16, at 2:45 p.m., the director of nursing stated the night nurses were responsible to go through the medication carts, but no one had ever been assigned to go through the medication rooms to ensure medications were not expired. An undated facility Medications To Date When Opened form was located in a Medication Administration Record (MAR) binder located on the East/West medication cart. The form identified the tuberculin solution should be discarded, "30 days after opening." A medication storage policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The	21610		

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21610	Continued From page 16 director of nursing (DON) or designee could develop systems to ensure monitoring of med carts and rooms for expired medications. The DON or designee could educate all licensed staff and TMA's. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21665	MN Rule 4658.1400 Physical Environment 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 Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a homelike dining environment for 2 of 3 dining rooms (Enhanced dining, Transitional Care Unit (TCU)) this had the potential to affect 37 out of 94 residents who ate in the two dinning rooms at the time of the survey. Findings include: During observation of the meal service in the main dining room, on 4/12/16, at 11:50 a.m., residents were seated at several square tables with seating for four residents. The tables were covered in aqua colored tablecloths and held salt and pepper shakers, a menu in an upright plastic holder, utensils, empty plastic cups, and clothing protectors. The residents were served restaurant	21665	Corrected	5/18/16

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21665	Continued From page 17	21665		

style, with dietary aides serving beverages and their lunch meal and placed it on the table in front of the residents for them to eat. No trays were used to serve the residents in this dining room during the lunch meal in the main dining room.

During observation 4/12/16, at 12:00 p.m. in the TCU dinning room six residents were observed to be sitting at a large table. Staff began to serve their meals on plastic trays. Staff left the plates and the glasses on the tray and placed the meal in front of the resident.

During an observation on 4/12/16, at 12:10 p.m. the enhanced dining room had six tables with seating for four residents at each table. The tables had clothing protectors at each resident's table spot. The enhanced dining room staff were passing residents their meal on trays. Staff was leaving the resident meal on the serving tray in front of the residents on the table. Staff was opening cartons of juice and milk for the residents and placing the empty containers in the thermal lids stacked in the middle of each table where residents were eating.

During interview 4/13/16, at 11:36 a.m. dietary supervisor (DS)-A stated the facility stopped using trays for the meal service in the main dining room a couple months earlier in order to make dining more homelike for the residents. DS-A stated the facility would like to stop using trays in all of the dining rooms, however no plan had been developed on how to accomplish this. Further, DS-A stated staff should not be placing the thermal plate covers in front of the residents and using them to store garbage.

During interview on 4/13/16, an anonymous family member stated they did not like seeing the

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21665	Continued From page 18 residents served on trays, "I don't understand why they serve the food on trays. I really think it would be nice if they would just put the plates on the tables and remove the trays. It would make it more home like for them." A policy was requested on home like dinning but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff regarding the importance of a safe, clean, and homelike dining environment. The DON or designee could coordinate with dietary staff to conduct periodic audits of dining areas to ensure a safe, clean, and homelike dining environment maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21665		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe and sanitary environment	21685	Corrected	5/18/16

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21685	Continued From page 19 was maintained for 3 of 3 resident rooms (W143, W126, W144) reviewed with ceiling tile damage, and 5 of 5 resident rooms (N135, N140, N133, N134, W146) reviewed with loose grab bars, cracks, and walls in disrepair. Findings include: On 4/13/16, at 11:00 a.m. a facility tour was completed with the maintenance director (MD), and the following environmental concerns were identified: CEILING TILES: Resident room W143 was observed to have five white suspended ceiling tiles which had brown stains. MD measured the tiles and staining on the five ceiling tiles which identified: 1: Ceiling tile measured 2' (feet) x (by) 4' with a brown, stained area that measured 3" (inches) x 7". 2: Ceiling tile measured 2' x 4' with a brown, stained area that measured 2.5" x 3". 3: Ceiling tile measured 2' x 4' with a brown, stained area that measured 2.5" x 2.5". 4: Ceiling tile measured 1' x 4' with a brown, stained area that measured 4" x 14". 5: Ceiling tile measured 1' x 4' with a brown, 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".	21685		

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21685	Continued From page 20 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. W144 was observed to have one white suspended ceiling tile, near the ceiling vent which had brown stains. MD stated the ceiling tile measured 2' x 4' with a brown, stained area that measured 4.5" x 9". MD stated the ceiling tile may have become stained from the air conditioning sweating adding, "I will replace this tile." GRAB BARS/ROOMS IN DISREPAIR: N135 was observed to have a loose and wobbly grab bar located between the sink and the toilet. In addition, an approximate 3" crack was observed in the interior surface of the wall behind the grab bar. MD agreed the grab bar was loose and there was a 3" stress crack behind the grab bar between the sink and the toilet. N140 was observed to have a loose and wobbly grab bar located between the sink and the toilet. MD stated the grab bar was loose, and he would tighten it. N133 was observed to have a loose and wobbly grab bar located between the sink and the toilet. MD stated he would tighten the grab bar, "I was not aware it was loose." N134 was observed to have an approximate 3"	21685		

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21685	Continued From page 21	21685		

crack on the interior surface of the the wall behind the grab bar. There were also several black scuff marks and gouges on the wall in the bathroom. MD stated there was a 3" crack behind the grab bar, and he would tighten the grab bar. MD also stated the scrapes and gouges on the wall should be patched and painted, "It is pretty scuffed up."

W146 was observed to have several black scuff marks and gouges on the lower portion of the wall. Two areas on this wall also had exposed sheetrock. MD stated the wall was in disrepair likely from the resident's wheelchair; there were several scuff marks on the lower portion of the wall in this room. Further, MD stated the scuffing on the wall measured 2' x 7' in size.

On 4/13/16, at 11:48 a.m. MD stated he used a preventative maintenance book and checked the grab bars on a monthly basis. MD stated staff should also be letting him know if they noticed grab bars are loosening or in disrepair, "I was not aware any of the grab bars we looked at today were loose until you showed them to me." MD stated loose fitting grab bars were a, "Safety issue" and they should be, "Tight and secure." Further, MD stated the observed ceiling tiles were stained and damaged and should have been replaced.

When interviewed on 4/13/16, at 1:08 p.m. the facility administrator stated the facility had no policy on checking ceiling tiles or checking grab bars for function.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could work with the director of building and grounds to develop a maintenance program to ensure stained celing

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21685	Continued From page 22 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	21685		