Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 26, 2023

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

RE: CCN: 245448
Cycle Start Date: March 30, 2023

Dear Administrator:

On May 18, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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April 17, 2023

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

RE: CCN: 245448
Cycle Start Date: March 30, 2023

Dear Administrator:

On March 30, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 30, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 30, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. BUILDING _____ B. WING _____	C 03/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/27/23 to 3/30/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/27/23 to 3/30/23, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. In addition to the recertification survey, The following complaints were reviewed with no deficiency issued. H54489524C/MN90871 H54489523C/MN89016 H54489525C/MN84626 H54489683C/MN83756 H54489683C/MN83788 H54489684C/MN83402 H5448066C/MN81748 The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 04/27/2023

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

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F 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		5/17/23

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F 550	Continued From page 2 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure a dignified rising routine was provided for 2 of 2 residents (R2, R43) reviewed who were dependent on staff for their care and who were left in bed fully dressed with the room lights turned on. Findings include: R2's care plan, printed 3/29/23, identified R2 was alert and oriented to self only, was mostly non-verbal, and required total staff assistance with bed mobility and repositioning. However, the care plan lacked any identified preferences (i.e., rising routine). R43's care plan, printed 3/29/23, identified R43 demonstrated periods of confusion, was unable to complete the Brief Interview for Mental Status (BIMS) evaluation, and required two staff and a mechanical lift for bed mobility. The staff were directed to anticipate needs if R43 was unable to unable to express himself. However, the care	F 550	Please accept the following as the facility□s credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. F550 Resident Rights/Exercise of Rights Additional questions have been added to the Activities, Hearing, Speech and Vision Evaluation Assessment for all new residents: 1. When do you usually wake up? 2. What is your morning routine after you wake up? 3. Do you like to nap? If so when? Before and/or after lunch? 4. When do you usually go to bed? 5. What is your bedtime routine? For existing residents who may have been	

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F 550	Continued From page 3 plan lacked any identified preferences (i.e., rising routine). On 3/29/23 at 7:08 a.m., R2 and R43's room was observed from the hallway with the doorway left open. R43 was visible from the hallway while he laid in bed with his eyes closed. R43 was fully dressed with a shirt and sweatpants, and the covers were pulled down to the foot of the bed. On the other side of R43, R2 was laying in bed with the bed in the low position. R2 was covered with a blanket in bed, however, had a visible shirt on. Both R43 and R2' eyes were closed; however, the room lights were all turned on. This remained until 7:25 a.m. (nearly 20 minutes later), when housekeeper (HK)-A knocked and entered the room with a carpet sweeper and empty trash bags. HK-A began to push the carpet sweeper around the room, including around each of the residents' bed, while they remained in bed with their eyes closed and the room lights all turned on. A few minutes later, HK-A could be heard aloud saying, "Good morning," to R2 on the other side of the room. HK-A then came over to R43's side of the room and opened a new trash bag next to his bed, despite R43 laying in bed with his eyes closed. At 7:30 a.m., nursing assistant (NA)-A pushed a mechanical lift into the room and voiced aloud they were "just going to put this in here for a minute until we get him [R43] up." At 7:31 a.m., NA-A and NA-B entered R43 and R2's shared room to provide care. The mechanical lift was then placed over R43 and he was assisted into a high-back wheelchair before being positioned in the corner of the room and covered with a blanket. The mechanical lift was then brought	F 550	impacted by this alleged deficient process, a new assessment has been created in our electronic medical records (PCC) with the questions noted above. This will be reviewed with all current residents by 5/17/2023 and answers will be incorporated into their existing care plans. Education will be provided to appropriate staff and will be completed by 5/17/2027. Residents will be assessed upon admission and information will be included in their Plan of Care. Audits will be performed on 4 residents/care plans per week to ensure these preferences are present. Results will be shared with the QAPI committee and adjustments made as advised by QAPI.	

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F 550	Continued From page 4 over to R2's bed and the bedding removed which exposed R2 was in bed while fully dressed in pants and a shirt. NA-A verified R2 was in bed covered up while fully dressed, and they explained R2 had a bath earlier that morning and the bath aide gets them dressed and puts them back into bed until, "We [NAs] come by and get him up" later on. NA-C then joined the interview. NA-B explained getting residents' dressed after bathing and placing them back in bed was not always the routine but rather depended on the person giving the baths. When questioned on how they (staff) know R2 was comfortable or accepting of this practice, NA-B responded they will ask the residents who "knows what's going on [i.e., cognitively intact]," and added R2 and R43 both used a mechanical lift to transfer so the staff "want [them] up as late as possible." NA-B stated they were unsure when R43 had been dressed that morning, and NA-C stated they had helped R43 get dressed while in bed "before seven [7:00 a.m.]" and they had purposefully left the lights on in the room since then (over 30 minutes) to help remind staff, including themselves, to get R2 and R43 up for the day. NA-C added, "That's my thing," and they "just do that." NA-C stated they felt R2 and R43 were comfortable and accepting of being left in bed fully dressed and with all the room lights being left turned on in the morning as neither of them had complained about it before. However, NA-C verified both had "very little" speaking abilities. On 3/29/23 at 10:01 a.m., licensed practical nurse (LPN)-A was interview. LPN-A stated they were not aware NA(s) were getting people dressed after bathing and returning them to bed fully dressed, nor were they aware staff were leaving room lights on to 'remind them' to get people up	F 550		

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F 550	Continued From page 5 for the day despite the residents' eyes closed and them being left to rest in bed while others are assisted. LPN-A questioned why the night shift or early bath NA would return the resident to bed; however, then added a benefit of returning them to bed was now staff could start the "check and change" process (i.e., check for incontinence every few hours). LPN-A stated they were unsure how, if ever, R2 and R43 had been assessed or questioned to ensure they were accepting of being returned or placed into bed fully dressed after morning care until staff were able to assist them. LPN-A explained, at times, the NA staff seem to make their own set of rules and change "certain things" without updating the nurses and added the NA staff needed "a lot more training" to reduce the risk of a "ripple effect" with bad habits, including getting residents dressed and returning them to bed or leaving them in bed with all the room lights on such as happened with R2 and R43. LPN-A expressed being returned to bed dressed or having the room lights intentionally left on while you rested was inappropriate adding, "I think it's rude," and, "It's inconsiderate." On 3/29/23 at 12:47 p.m., R2's family member (FM)-A was interviewed, and they explained R2 did not speak much, if ever, and required total care from the staff. FM-A stated they were unaware R2 was being dressed and returned to bed after bathing but expressed such action didn't surprise them adding, "[It's] probably for their own things they have to get done." FM-A stated they had never been asked or questioned if such practice would be acceptable for R2; however, FM-A stated R2 would have never done such practice prior to moving into the nursing home adding, "Oh God, no."	F 550		

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F 550	Continued From page 6 R2 and R43's medical record(s) were reviewed and lacked evidence they had been assessed or questioned on being dressed and placed back into bed as had been observed. Further, there was no evidence they had been asked or assessed to determine if staff leaving the room lights turned on for extended periods of time while they were resting in the morning (i.e., waiting for staff to assist them after being dressed) was acceptable to them. On 3/29/23 at 1:10 p.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed. The DON explained R2 had been bathed and dressed and returned to bed and staff will "leave them there" until there were two people to assist with transfer(s) using the mechanical lift. DON explained it as staff will "tag team" the mechanical lift residents then as it was not always possible to delay the baths while they assisted people with morning care and rising adding, "[the baths] have to keep goin' on." DON and ADON both acknowledged there was no formal process to assess or determine if residents, including those who could not speak for themselves in the moment, were accepting of this practice or having the room lights left on for extended periods while they're left in bed to rest. In addition, the ADON stated there was no reason for lights to be left on to alert or remind staff to get residents' up for the day. A facility' policy on dignity or rising preferences was requested, however, none was received.	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		5/17/23

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F 684	Continued From page 7 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to ensure proper wheelchair positioning and prevent potential complications for 2 of 2 residents (R50 and R61) reviewed. Findings include: R50's quarterly Minimum Data Set (MDS) dated 3/10/23, identified R50 had severe cognitive impairment. Further, R50's care plan identified R50 had a self-care deficit and required assistance with transfers and locomotion and utilized a wheelchair. R50's physical therapy note dated 8/7/22, identified, "Ordered foot strap for pt [patient] to use on w/c [wheel chair] to properly position when w/c is tilted." During continuous observation on 3/28/23, from 2:17 p.m. to 2:33 p.m. R50 was seated in a Broda wheelchair (a reclining wheelchair) in the living room area. R50's wheelchair was reclined in a laying position with R50 sitting upright in wheelchair holding his head/neck up. R50's feet were not touching the floor due to being reclined back and legs/feet were dangling in the air with	F 684	F684 Quality of Care The wheelchair positioning policy has been updated to ensure that residents who require the use of a wheelchair have access to safe and appropriate equipment and that staff members are trained in the proper use and maintenance of wheelchairs. R50 has an appropriate wheelchair to meet his needs as well as appropriate equipment for the chair to provide for proper positioning. Staff education has been provided. All residents who require the use of a wheelchair have been determined to have safe and appropriate equipment for mobility and positioning. Nursing and therapy staff will be educated on this updated policy by 5/17/2023. Nursing and therapy will complete 10 audits per month for 3 months. Audits will be decreased based on compliance and recommendation from QAPI committee.	

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F 684	Continued From page 8 no support and/or footrests under them. At 2:22 p.m. R50 was attempting to lean forward in wheelchair, was swinging his legs back and forth which were suspended in the air. Multiple staff walked past the area and did not assist to reposition R50. At 2:25 p.m. R50 was leaning forward, reaching out and attempting to get out of wheelchair. R50 was lifting buttock off seat and was trying to scoot to the edge of wheelchair seat. R50 was swinging legs back and forth and was attempting to get feet on ground. At 2:29 p.m. R50 was attempting to take arm out of his shirt and then attempted to stand up again, which R50 was unable to get to standing position due to wheelchair being reclined. At 2:30 p.m. R50 was raising his hand and was attempting to get out of wheelchair again. Multiple staff walked past area, looked at R50 and continued walking by. Staff did not stop and attempt to assist R50. At 2:33 p.m. R50 was waving at staff who came and assisted R50 with going on a walk. On 3/29/23, at 7:05 a.m. R50 was sitting in wheelchair behind the nurse's desk. Wheelchair is reclined all the way back with R50 attempting to hold himself up in an upright seated position. R50's legs/feet were suspended in the air with no foot pedals present on wheelchair. At 7:11 a.m. R50 was leaning forward in wheelchair and was swinging legs/feet to attempt to place them on the floor. At 7:18 a.m. R50 was again leaning forward to place feet on the floor. R50 was rocking back and forth and was attempting to push off wheelchair arm rests with his arms. At 7:25 a.m. multiple staff walked past R50, looked at R50, and continued walking without assisting R50. At 7:27 a.m. R50 scooted forward in wheelchair, pushed off the arm rests of wheelchair with both arms and got toes on the floor. R50 pushed his	F 684		

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	245448	A. BUILDING _____ B. WING _____	C 03/30/2023

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F 684	Continued From page 9 wheelchair backwards using his left toes that were barely on floor. At 7:29 a.m. nursing assistant (NA)-B came in living room area with another resident, saw R50 attempting to take arm out of sleeve and assisted R50 with putting his arm back in sleeve. NA-B then walked away and did not assist R50 with repositioning in wheelchair. At 7:32 a.m. R50 was swinging legs back and forth in midair. At 7:33 a.m. R50 was leaning forward in wheelchair and was pushing off arm rests with both arms. Licensed practical nurse (LPN)-A went up to R50 and talked to him and then went back to med cart and did not assist R50 with repositioning. At 7:35 a.m. LPN-A went up to R50 and asked R50 "where do you want to go" as R50 was again attempting to place feet on the floor. At 7:37 a.m. LPN-A brought R50 a snack and a cup of water and placed on bedside tray table on R50's right side. At 7:48 a.m. R50's foot pedals were laying on the floor in R50's room. At 8:08 a.m. R50 was sitting in wheelchair with his eyes closed with his legs dangling in mid-air. At 8:12 a.m. staff went up to R50 and assisted with applying a face mask but did not attempt R50 with repositioning. At 9:09 a.m. R50 was still sitting in living room area with his wheelchair reclined and legs/feet dangling. On 3/29/23, at 2:36 p.m. R50 was sitting in living room area with wheelchair reclined, legs/feet dangling in mid-air and was sitting forward by pushing off with both arms on arm rests of wheelchair. During interview on 3/30/23, at 9:06 a.m. NA-E stated the footrests should be used for everyone that has them and that needs assistance. NA-E stated, "I like them comfortable." NA-E stated R50 sometimes uses foot pedals and when not	F 684		

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F 684	Continued From page 10 using foot pedals, a foot stool should be always placed under his feet. NA-E also stated that if R50 appears to be restless R50 should be assisted to the restroom. NA-E stated that R50 never speaks of pain or has had complaints. During interview on 3/30/23, at 9:08 a.m. NA-C stated that footrests should be used for everyone who needs assistance with wheelchairs. During interview on 3/30/23, at 9:11 a.m. LPN-C stated that R50 is supposed to always use foot pedals and that foot pedals should be always used if the resident needs assistance. LPN-C stated R50 should be repositioned as often as he asks or every 2 hours and as needed. LPN-C stated that R50 has had no complaints or signs/symptoms of pain. LPN-C stated that R50's wheelchair is not supposed to be reclined all the way back and if R50 is sleeping while in wheelchair, a foot stool should be placed under his feet to support his legs/feet. During interview on 3/30/23, at 9:47 a.m. Director of Nursing (DON) stated foot pedals aren't typically used on resident's who can propel themselves. Foot pedals are used per resident preference and for comfort. DON stated that R50 should have foot pedals on but also stated that she thinks that R50 prefers for his feet to be dangling. DON stated that staff should intervene when R50 is dangling his legs/feet and is attempting to push himself up off his arm rests. R61's quarterly MDS dated 3/17/23, identified R61 had severe cognitive impairment. Further, R61's care plan identified R61 had a self-care deficit and required assistance with transfers and	F 684		

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F 684	Continued From page 11	F 684		

locomotion in a wheelchair to reach desired destinations and utilized a wheelchair.

During observation on 3/27/23, at 12:40 a.m. R61 was being pushed down hallway in his wheelchair with no foot pedals on. R61's feet were dragging and bouncing on floor with staff providing two reminders to R61 to hold his feet up. R61 would hold feet up and then immediately drop them.

On 3/28/23, at 8:34 a.m. R61 was assisted to breakfast in wheelchair. R61's feet were dragging and bouncing on floor and staff provided reminders to R61 to hold his feet up. R61 would hold feet up and then immediately drop them.

On 3/28/23, at 9:16 a.m. R61 was assisted back to living room area from breakfast. R61's wheelchair was reclined all the way back so that R61's feet were just up off the floor. No foot pedals were on wheelchair. When R61 got to desired location, staff sat R61 back up in upright position with feet placed on floor.

On 3/29/23, at 7:36 a.m. R61 was sitting in his wheelchair with no foot pedals on wheelchair. At 7:48 a.m. foot pedals were seen laying on the floor in R61's room. At 8:15 a.m. NA-B assisted R61 to dining room in wheelchair with no foot pedals on wheelchair. R61's feet dropped once while being propelled down hallway between living and dining room. NA-B stopped and reminded R61 to keep his feet up. At 9:11 a.m. trained medication aide (TMA)-A assisted R61 back from dining room to living room. Wheelchair was reclined all the way back so that R61's feet were just off the ground with no foot pedals on wheelchair. R61's left foot bounced off the ground one time and when R61 got to living room area,

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F 684	Continued From page 12 TMA-A sat wheelchair up in an upright position with R61's feet placed on floor. On 3/29/23, at 2:34 a.m. R61 was sitting in the living room area with wheelchair being reclined all the way back and R61 was struggling to hold his head up. On 3/30/23, at 9:03 a.m. foot pedals were observed laying on floor in R61's room. During interview on 3/30/23, at 9:06 a.m. NA-E stated the footrests should be used for everyone that has them and that needs assistance. NA-E stated, "I like them comfortable." NA-E stated that R61 has a reclining wheelchair, and that staff leans R61 back when they push wheelchair so that his feet are "a little off the floor." During interview on 3/30/23, at 9:08 a.m. NA-C stated that footrests should be used for everyone who needs assistance with wheelchairs. During interview on 3/30/23, at 9:11 a.m. LPN-C stated that R61 is supposed to always use foot pedals and that foot pedals should be always used if the resident needs assistance. During interview on 3/30/23, at 9:47 a.m. Director of Nursing (DON) stated that foot pedals aren't typically used on resident's who can propel themselves. Foot pedals are used per resident preference and for comfort. DON stated that if a resident is not able to hold their legs up that foot pedals should be used. DON stated R61 used to propel himself but that R61 has had a decline where he is not able to hold his feet up anymore so "yes we should be putting foot pedals on."	F 684		

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F 684	Continued From page 13 During interview on 3/30/23, at 10:09 a.m. Licensed Physical Therapist stated that whenever staff must assist a resident with their wheelchair from destination to destination and if a resident is unable to hold feet up, foot pedals should be used. R61's medical record was reviewed and lacked evidence that R61 had been assessed or screened for wheelchair positioning by physical therapist. A wheelchair positioning policy was requested but was not provided.	F 684		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing	F 700		5/17/23

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F 700	Continued From page 14 and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure alternate interventions were assessed and/or attempted prior to side rail installation for 1 of 1 resident (R43) reviewed who required total assistance with mobility and had one-half (1/2) side rails installed on their bed. Findings include: R43's quarterly Minimum Data Set (MDS), dated 12/23/22, identified R43 had severe cognitive impairment and required extensive to total assistance for transfers and bed mobility. Further, the MDS outlined R43 did not use bed rails (i.e., restraints). On 3/27/23 at 1:41 p.m., R43 was observed laying in bed while in his room. R43 used a bariatric-sized bed which had bilateral metal one-half side rails affixed and raised on each side. R43 was positioned in the middle of the bed and his eyes were closed. R43 did not verbally respond when conversation was attempted. On 3/29/23 at 7:08 a.m., R43 was again observed in bed with the metallic, bilateral one-half side rails raised up and locked with a mechanical lift sling placed underneath of him. R43's eyes were closed and he was positioned in the middle of the bed on his back. Later on, at 7:31 a.m., nursing assistant (NA)-A and NA-B entered R43's room to provide morning care and get R43 up from bed. A mechanical lift was used to transfer R43 up from the bed surface, over the raised one-half side rails, and then into his wheelchair. NA-A was	F 700	F700 Bedrails The grab bar assessment within Point Click Care (Our electronic medical record) has been updated to include the question: Have alternate options been reviewed? This also includes a text box to list alternatives identified and a check box to indicate that no alternatives can be identified. The grab bar policy has been updated to include the assessment of alternatives. These assessments are consistently done by our ADON. He has been educated on the updated policy and additions to the PCC assessment. R43 has been re-assessed and no alternative for bed mobility has been identified. Grab bars remain in place at this time. All other current residents with grab bars in place for bed mobility will be re-assessed for any identifiable alternatives.	

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F 700	Continued From page 15 interviewed and expressed they were "not sure" how long R43 had the rails installed on the bed but it had been for some time now. NA-A explained R43 used to help staff with bed mobility and use the rails more in the past, however, R43 had declined over the past few weeks and was "really not using them now too much." NA-A stated there were still, at times, some moments when R43 was able to grab one and hold the rails with repositioning, however, reiterated the decline which NA-A verified the nurses were aware of. Further, NA-A expressed R43 had not sustained any recent falls from bed or injuries from the rails to their knowledge, and they stated they had never seen any other devices (i.e., smaller grab bars) attached to the bed prior to the metallic one-half rails currently used. R43's Physical Device Evaluation - V2, dated 9/22/22, identified an annual review of the device(s) was completed, and R43 used a left and right grab bar on their bed. The evaluation outlined, "Resident is a hoyer transfer to bed and [wheelchair] is assist of two." However, a provided section labeled, "Alternate Interventions," was left blank and not completed. R43's Grab Bar Assessment, dated 12/16/22, identified R43 used bilateral grab bars and they were not considered a restraint but rather for mobility purposes. R43 was determined to show appropriate use of the devices with verbal direction needed at times to, " ... grab on at times." R43 had sustained no recent falls from bed and R43 and/or family had been educated on the devices and their benefits. However, the completed assessment lacked what, if any, alternate interventions had been attempted prior to installing the devices on R43's bed. In addition,	F 700		

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F 700	Continued From page 16 R43's subsequent Grab Bar Assessment, dated 2/24/23, identified R43 used bilateral grab bars and they were not considered a restraint but rather for mobility purposes. R43 was determined to show appropriate use of the devices with dictation added, "[R43] may need cues to grab on at times." R43 had sustained no recent falls from bed and R43 and/or family had been educated on the devices and their benefits. However, again the completed assessment lacked what, if any, alternate interventions had been attempted prior to installing the devices on R43's bed. Further, R43's most recent Physical Device Evaluation - V2, dated 3/21/23, identified a significant change assessment was being completed, and R43 continued with both a left and right sided grab bar attached to the "Hi-low Bed." The evaluation outlined R43 was able to safely demonstrate use of the devices adding, " ... use bilateral grab bars in bed for positioning and with cares ... no safety concerns noted ... " However, again the section labeled, "Alternate Interventions," was left blank and not completed. R43's care plan, printed 3/29/23, identified R43 had an activities of daily living (ADL) self-care deficit and was non-ambulatory. The care plan outlined, "BED MOBILITY: The resident requires AX2 [assist of two] staff participation to get in/out of bed using a Hoyer as well as to reposition and boost. GB X2 [grab bar bilaterally]." However, the care plan lacked what, if any, alternate interventions had been attempted or considered prior to the grab bar/side rail installation on the bed. Further, R43's medical record was reviewed and lacked documentation on what, if any, alternate interventions or options had been assessed or considered prior to the installation of	F 700		

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F 700	Continued From page 17 the metallic, bilateral one-half side rails on the bed despite R43 needing near total assistance with bed mobility and transfers, and R43 having declined with their abilities to use the devices in the past weeks as voiced by the direct care staff. When interviewed on 3/29/23 at 10:01 a.m., licensed practical nurse (LPN)-A verified they were aware R43 had the bilateral, metallic one-half rails installed, and R43 had them "since [I] worked here." LPN-A stated they understood a consent was needed to use the devices, and a "device evaluation" was needed in the medical record which, to their understanding, was completed by the therapy department. However, LPN-A stated they had noticed R43 did not really use the rails for mobility anymore adding, "I don't see him use them." LPN-A stated they were unsure why R43 still had the one-half side rails installed if they were not being used to promote mobility adding, "Honestly, I don't know." Further, LPN-A reiterated therapy needed to "assess those things [the rails]," as nurses "can't make the decision" on their use. On 3/29/23 at 1:10 p.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed. ADON explained R43 was non-ambulatory and needed a mechanical lift to transfer in and out of the bed; however, at times, would still grab and use the rails to help the aides when they reposition him in bed. ADON stated R43 used a bariatric bed and the rails "come with" the bed and were designed for the exact bed to be used; however, they considered them to be grab bars and not side rails. ADON stated the devices were not a restraint but rather in place to "promote ability or independence" with care. ADON was aware R43 had declined in	F 700		

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F 700	Continued From page 18 ability, and overall condition, in the past few weeks; however, reiterated they felt R43 still benefited from the bars being installed as R43 could still grab one at times. Further, ADON and DON both acknowledged the section of the device evaluations with alternate options being left blank and not completed and expressed they were not sure what, if any, alternative interventions had been attempted in the past or if any even could be currently. A provided Grab Bar Assessment Policy, dated 1/2023, identified each resident would be assessed by therapy or nursing for the proper use of grab bars for mobility. This would be assessed on a quarterly basis and consent obtained and signed. However, the policy lacked any direction or information on how alternative options and/or interventions would be assessed and documented prior to the installation of side rails or grab bars.	F 700		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		5/17/23

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F 757	Continued From page 19 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) narcotic medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., constipation, sedation) for 1 of 5 residents (R336) reviewed for unnecessary medication use. Findings include: R336's Admission Record, dated 3/29/23, identified R336 admitted to the nursing home on 3/23/23 from the acute care hospital. Further, R336's (hospital) Interagency Physician Discharge Orders/Instructions, dated 3/17/23, identified R336 was stable at the time of discharge and would be admitted to the skilled nursing facility. A section labeled, "Discharge Medication Orders," which included an order for oxycodone (a narcotic medication) 5 - 10 milligrams (mg) by mouth every four hours PRN for post-surgical pain. R336's Nursing Assessment/Initial Care Plan, dated 3/23/23, identified R336 was alert and oriented to person, place, and time. A section labeled, "Pain Control," outlined R336 had pain in	F 757	F757 Free from unnecessary drugs Our electronic medical record has been updated (Point Click Care) to note that non-pharmacological interventions must be offered/tried before PRN pain medication is used. At least one non-pharmacological intervention must be indicated. Nurse must chart a yes/no for each non-pharm option. Space is available and it is required that documentation indicate what patients current pain feels like. This documentation is required and alternative interventions include options of ice, massage, quiet, repositioning, TV or other entertainment. In addition, the admission assessment has been updated with questions that include: What typically alleviates your pain? What makes your pain worse? What non-pharmacological interventions have you tried in the past? The information provided by the patient will be included in the plan of care. Education will be provided to all appropriate nursing staff and will include	

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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 757	Continued From page 20 their right leg along with a, "Pain Goal," of 2/10 (0-10 scale; 10 being worst pain). Further, the care plan identified R336 consumed both scheduled and PRN medication for pain, however, the care plan lacked what, if any, non-pharmacological interventions were going to be used and/or attempted for R336. On 3/27/23 at 3:16 p.m., R336 was observed seated in a wheelchair in her room. R336 had a visible brace around their right leg and a white-colored dry erase board displayed on the wall which outlined, "Next Oxycodone 9:35 AM," in black marker. R336 stated aloud, "that's a lie," while referencing the time on the board. R336 was interviewed and expressed they admitted to the nursing home from the hospital with a recent amputation on their right leg. R336 stated they were frustrated with their pain management at the nursing home as staff had not been "very consistent" with their approaches, both pharmacological and non-pharmacological, to manage it. R336 described their right leg pain as a "burning" sensation and like the leg had been "set on fire." Further, R336 stated some non-pharmacological interventions, such as repositioning or heat packs, did somewhat help the pain but added the pain medication seemed to work best. R336's Medication Administration Record (MAR), dated 3/2023, identified R336 admitted to the nursing home on 3/23/23, and listed all of R336's ordered medications and treatments with corresponding initials to demonstrate the administration. This identified R336 consumed oxycodone four times daily along with an order which read, "oxyCODONE ... 5 mg Give 1 tablet by mouth every 4 hours as needed for pain ...,"	F 757	information on how to order PRN medications; review of our medication administration policy and alternatives to offer. Education will be completed by 5/17/2023. This new assessment and process has been put in place for R336 and for all current residents who have orders for PRN pain medication. Audits will be completed on 10 prn medications per week for 6 weeks. The results will be shared at QAPI. IF compliance is greater than 90%, we will decrease to 5 audits per week. We will adjust audits based on compliance and direction from QAPI committee.	

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F 757	Continued From page 21 with a stop date of 3/27/23. A total of nine doses were administered as follows: On 3/24/23 at 7:13 a.m., with R336 rating the pain at 4/10, and the results being listed as "Effective." A corresponding progress note, dated 3/24/23, identified the medication was given with an indication recorded as "R leg," however, lacked any further information on what symptoms were displayed or what, if any, non-pharmacological interventions were attempted prior to the administration. On 3/24/23 at 11:53 a.m., with R336 rating the pain at 8/10, and the results being listed as "Effective." A corresponding progress note, dated 3/24/23, identified the medication was given with an indication recorded as "RLE [right lower extremity]," however, lacked any further information on what symptoms were displayed or what, if any, non-pharmacological interventions were attempted prior to the administration. On 3/25/23 at 12:32 a.m., with R336 rating the pain at 4/10, and the results being listed as "Unknown." A corresponding progress note, dated 3/25/23, identified the medication was given with an indication recorded as "Patient c/o [complained] 4/10 right leg pain," however, lacked any further information on what, if any, non-pharmacological interventions were attempted prior to the administration. On 3/25/23 at 11:01 a.m., with R336 rating the pain at 5/10, and the results being listed as "Ineffective." A corresponding progress note, dated 3/25/23, identified the medication was given, however, lacked any further information on what symptoms were displayed or what, if any,	F 757		

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F 757	Continued From page 22 non-pharmacological interventions were attempted prior to the administration. On 3/25/23 at 8:19 p.m., with R336 rating the pain at 5/10, and the results being listed as "Effective." A corresponding progress note, dated 3/25/23, identified the medication was given with an indication recorded as "Complaints of RLE pain," however, lacked any further information on what, if any, non-pharmacological interventions were attempted prior to the administration. On 3/26/23 at 8:50 a.m., with R336 rating the pain at 5/10, and the results being listed as "Effective." A corresponding progress note, dated 3/26/23, identified the medication was given, however, lacked any further information on what symptoms were displayed or what, if any, non-pharmacological interventions were attempted prior to the administration. On 3/26/23 at 1:23 p.m., with R336 rating the pain at 5/10, and the results being listed as "Effective." A corresponding progress note, dated 3/26/23, identified the medication was given, however, lacked any further information on what symptoms were displayed or what, if any, non-pharmacological interventions were attempted prior to the administration. On 3/26/23 at 7:44 p.m., with R336 rating the pain at 5/10, and the results being listed as "Effective." A corresponding progress note, dated 3/26/23, identified the medication was given with an indication recorded as "Complains of RLE pain," however, lacked any further information on what, if any, non-pharmacological interventions were attempted prior to the administration.	F 757		

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F 757	Continued From page 23 On 3/27/23 at 5:29 a.m., with R336 rating the pain at 4/10, and the results being listed as "Effective." A corresponding progress note, dated 3/26/23, identified the medication was given, however, lacked any further information on what symptoms were displayed or what, if any, non-pharmacological interventions were attempted prior to the administration. The MAR outlined an additional order which read, "OxyCODONE ... 5 mg ... 2 tablet by mouth every 4 hours as needed for Pain rate of 6-10," with a listed stop date of 3/27/23. This identified three administrations of the medication as follows: On 3/23/23 at 9:37 p.m., with R336 rating the pain at 6/10, and the results being listed as "Effective." A corresponding progress note, dated 3/23/23, identified the medication was given, however, lacked any further information on what symptoms were displayed or what, if any, non-pharmacological interventions were attempted prior to the administration. On 3/24/23 at 5:44 p.m., with R336 rating the pain at 9/10, and the results being listed as "Effective." A corresponding progress note, dated 3/26/23, identified the medication was given with an indication recorded as "9/10 RLE pain/pressure," however, lacked any further information on what, if any, non-pharmacological interventions were attempted prior to the administration. On 3/27/23 at 9:55 a.m., with R336 rating the pain at 6/10, and the results being listed as "Effective." A corresponding progress note, dated 3/26/23, identified the medication was given with an indication recorded as "RLE," however, lacked	F 757		

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F 757	Continued From page 24 any further information on what, if any, non-pharmacological interventions were attempted prior to the administration. In addition, the MAR and Treatment Administration Record (TAR) lacked evidence of any recorded non-pharmacological interventions being attempted prior to the administration of the as-needed narcotic medication to ensure it was needed. When interviewed on 3/29/23 at 9:01 a.m., nursing assistant (NA)-D stated R336 needed "total assist" with cares and did have ongoing complaints of pain which the NA(s) report to the nurse so it can be addressed adding, "We don't do medications." NA-D stated staff did, at times, offer ice packs to R336 which should usually refused, however, seemed to "sometimes" accept from the therapy staff to help reduce her pain. NA-D stated she was unsure if R336's pain seemed to be, overall, improving since admission to the nursing home. On 3/29/23 at 9:14 a.m., licensed practical nurse (LPN)-B was interviewed. LPN-B explained R336 did verbalize complaints of pain, at times, and will often ask the NA(s) to alert the nurse for pain medication. LPN-B expressed R336 "does not like the ice packs," and trying to reposition her to alleviate pain can "get kind of difficult," however, LPN-B added, "I haven't gotten to know her [R336] a ton." LPN-B explained the process to give as-needed pain medication included asking the resident to rate their pain (i.e., 1-10 scale) and staff use a "pain interview" to document pain levels for the first few week of their admission. LPN-B reviewed R336's medical record, and corresponding PRN oxycodone administration	F 757		

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F 757	Continued From page 25 notes, and stated they "haven't done a lot of documentation like that [i.e., non-pharmacological interventions]." LPN-B added, "I could, probably should." Further, LPN-B stated non-pharmacological interventions were important to attempt and document to help staff "know what's going on" with the resident and to ensure they weren't under or over medicated. When interviewed on 3/29/23 at 1:04 p.m., the director of nursing (DON) verified they had reviewed R336's medical record and it lacked documentation of what, if any, non-pharmacological interventions were being attempted prior to the administration of the PRN narcotic medications. DON added, "[Staff] are just not capturing that [the data]." The DON explained they "have some thoughts about that," but expressed non-pharmacological interventions should be attempted and recorded with administration of PRN narcotic medication to ensure the medication was actually needed as "medication can interfere" with a person. Further, the DON acknowledged R336 was within her Minimum Data Set (MDS) reference period and the data of what, if any, non-pharmacological interventions which worked was important to the overall medication management and assessment process adding, "I get that." A facility' policy on medication management was requested, however, none was received.	F 757		

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	245448	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2023**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/28/2023. At the time of this survey, Park River Estates Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. Park River Estates Care Center is a 1-story building without a basement. The building was constructed at three different times. The original building was built in 1967 and was determined to be of Type II(222) construction. In 1988, an addition was constructed as the South Wing that was determined to be of Type II(111) construction. Finally, another addition was added in 1992 to the East Wing and was determined to be of Type II(111). The facility was surveyed as one building because the original building and the two additions conform to the lower protected construction type allowed for existing buildings. Multiple smoke compartments separate the building for a shelter-in-place strategy. The facility is fully protected throughout by an automatic fire sprinkler system. In addition, the facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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

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 The facility has a capacity of 99 beds and had a census of 85 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		