



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 5, 2026

Administrator

PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC
9899 AVOCET STREET NORTHWEST
COON RAPIDS, MN 55433

RE: CCN:245448

Cycle Start Date: July 24, 2026

Dear Administrator:

On July 24, 2026, a survey was completed at your facility by the Minnesota Department of Health 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:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 October 24, 2026 (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 January 24, 2027 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 5, 2026

Administrator

PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC
9899 AVOCET STREET NORTHWEST
COON RAPIDS, MN 55433

Re: State Nursing Home Licensing Orders

Event ID: 2AAD39-H1

Dear Administrator:

The above facility survey was completed on July 24, 2026 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 26, 2026

Administrator
PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC
9899 AVOCET STREET NORTHWEST
COON RAPIDS, MN 55433

RE: CCN: 245448
Cycle Start Date: July 24, 2026

Dear Administrator:

On August 21, 2026, the Minnesota Department of Health 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.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 26, 2026

Administrator

PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC
9899 AVOCET STREET NORTHWEST
COON RAPIDS, MN 55433

Re: Reinspection Results
Event ID: 2AAD39-H2

Dear Administrator:

On August 21, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 24, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
F0000	INITIAL COMMENTS On 6/23/26 and 6/24/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54483462C (3107429). As a result of the investigation deficiencies were cited at F692. The facility's plan of correction (POC) will serve as your allegation of compliance upon the 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.			F0000			08/17/2026
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences			F0692	1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? The identified liquids were removed from R3 room. R3 is receiving the correct physician prescribed liquids. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with physician orders for altered liquid consistencies were audited, and residents are receiving the correct physician prescribed		08/17/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
F0692 SS = D	Continued from page 1 indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review the facility failed to ensure a therapeutic mechanically altered hydration plan was provided and maintained for 1 of 3 residents (R3) reviewed for change in condition. Findings include: R3's annual Minimum Data Set (MDS) dated 4/24/26 indicated severe cognitive impairment, a mechanically altered diet, supervision or touch assistance for eating, and diagnoses that included gastroesophageal reflux disease (the stomach contents flow backward into the esophagus and may cause difficulty or pain when swallowing), malnutrition, arthritis, and dementia. R3's care plan indicated the following: 5/7/26 Resident was alert and oriented to person and place with periods of confusion with an intervention to anticipate and meet needs when if resident was unable to express himself. 6/12/26 Resident had a self-care performance and mobility deficit related to cognitive concerns, pain, and osteoarthritis with an intervention to eat independently after set-up, with supervision. 7/23/26 Resident had a nutritional problem or potential nutritional problem with need for nectar-thick liquids due to dysphagia (swallowing disorder) with an intervention to provide nectar-thick liquids. R3's progress note dated 7/23/26, indicated that R3 returned from the hospital with pneumonia on a dysphagia diet and required supervision with meals. The progress notes diagnoses list further indicated pneumonia due to inhalation of food. R3's orders indicated the following:			F0692	Continued from page 1 liquid consistency. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Nursing and culinary staff were re-educated on ensuring residents are getting the physician ordered liquid consistency. 4. Monitoring to ensure compliance DON /designee will conduct weekly audits for four weeks for the residents receiving altered liquid consistencies to verify that the physician-prescribed liquid consistency diets are given to the resident. The results of the audits will be reviewed at the QAPI meeting for determination of ongoing audits. 5. Date corrective action will be completed? Facility is alleging compliance on 8/17/2026. Submission of this Plan of Correction does not constitute an admission or agreement by Park River Healthcare and Rehabilitation as to the accuracy of the alleged deficiencies cited in the Statement of Deficiencies. This Plan of Correction is submitted as required by applicable regulations and is intended to demonstrate Park River Healthcare and Rehabilitation commitment to compliance and to provide a plan for achieving and maintaining substantial compliance. Park River Healthcare and Rehabilitation reserves the right to contest the findings and conclusions contained in the Statement of Deficiencies.		08/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
F0692 SS = D	Continued from page 2 7/15/26 indicated a regular diet with pureed texture and nectar consistency liquids 7/15/26 indicated no straws per family/dysphagia diet R3's breakfast tray card dated 7/23/26 for breakfast indicated a pureed diet with nectar thick liquids. During an interview on 7/23/26 at 1:23 p.m., the speech language pathologist (SLP)-A stated signs of aspiration included coughing, a wet vocal quality after swallowing liquids, throat clearing, and shortness of breath. During an interview on 7/23/26 at 4:34 p.m., with the family member (FM)-A stated on 7/23/26 around 9:30 a.m., when FM-A was visiting, a nursing assistant (NA) dropped off R3's breakfast tray with two cups of liquids that were not thickened and a water pitcher with water that was not thickened with a straw in it. The FM-A stated all R3's liquids were supposed to be thickened, and R3 was not allowed to use a straw. The FM-A stated she was aware of R3's dietary restrictions and asked the NA to get some thickener for the water, and the NA left the room and did not return. The FM-A stated she ensured that R3 did not consume any of the liquids provided at breakfast, but if she had not been present, he may have consumed them. During an observation on 7/23/26 at 4:34 p.m., R3's meal ticket from 7/23/26's breakfast indicated a pureed diet with nectar thick liquids. R3's breakfast was sitting on a dresser in the room and contained two glasses of liquid the FM-A identified as water and apple juice that were not thickened. R3's water pitcher contained water that was not thickened and a straw, but was out of reach of R3, and the FM-A did not allow R3 to use it. During an observation on 7/23/26 at 4:55 p.m., the administrator observed R3's liquids on the breakfast tray. During an interview on 7/23/26 at 4:55 p.m., the administrator stated she was unsure if he liquids were thickened and thought if they had been thickened, they might get thinner throughout the day but wasn't sure. The FM-A gave the administrator a description of the NA who dropped off the tray, and the administrator stated she would try to identify the staff based on the schedule.			F0692			08/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
F0692 SS = D	Continued from page 3 During an interview on 7/24/26 at 11:41 a.m., the NA-C acknowledged she cared for R3 the morning, of 7/23/26, and delivered his breakfast tray to the room and did not know R3's dietary order specified thickened liquids until the evening of 7/24/26, when the director of nursing (DON) called her to re-educate her about the meal ticket process. The NA-C acknowledged she should have looked at R3's meal ticket more carefully and had another staff verify the tray was set up correctly but had not. The NA-C stated she had read R3's meal ticket previously and was unsure when R3's needs changed to thickened liquids and stated she had never provided R3 with thickened liquids. The NA-C stated R3 was not supposed to have a water pitcher with a straw, and R3 should have been provided with thickened liquids separately. During an interview on 7/24/26 at 1:13 p.m., the NA-A stated when the NAs passed trays, the NAs were supposed to review the meal tickets and have another staff verify the tray is set up correctly. During an interview on 7/24/26 at 1:23 p.m. the licensed practical nurse (LPN)-A stated when a resident was at risk of aspiration, they required either nectar or honey consistency fluids, could not have a water pitcher in their room, and could not use a straw. If the precautions were not followed, the resident could choke. During an interview on 7/24/26 at 1:41 p.m., the LPN-B stated aspiration precautions included an order for no straw, no water pitcher in the room, and staff had to ensure residents received he fluids of the correct consistency or they could cough or choke. The LPN-B stated she was working 7/23/26 but was not aware R3 received a water pitcher with a straw or the wrong fluids as that would not be safe for R3. During an interview on 7/24/26 at about 4:02 p.m., the DON stated aspiration precautions included staying upright with oral intake, following the ordered liquid consistency and food texture orders, and encourage the residents to stay sitting up for half an hour after meals. During an interview on 7/24/26 at the regional director of clinical services (RDCS)-A stated after she learned R3 received the incorrect liquid consistency on 7/23/26, she implemented orders to listen to lung sounds and perform vital signs every shift for three days to monitor R3's condition. R3 had an SLP evaluation to ensure he the thickened liquid recommendations were appropriate. The			F0692			08/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245448		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
F0692 SS = D	Continued from page 4 RDCS-A stated the facility did not have a policy for aspiration precautions.			F0692			08/17/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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	
20000	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: On 7/23/26 and 7/24/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed with no deficiency issued. H54483462C (3107429).		20000			08/17/2026	

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
20000	Continued from page 1 As a result of the investigation a licensing order was issued at 0940. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.			20000			08/17/2026
20940	Rehab - Hydration CFR(s): MN Rule 4658.0525 Subp. 9 Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This LICENSURE REQUIREMENT is NOT MET as			20940	CORRECTED		08/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
20940	Continued from page 2 evidenced by: Based on interview, observation, and document review the facility failed to ensure a therapeutic mechanically altered hydration plan was provided and maintained for 1 of 3 residents (R3) reviewed for change in condition. Findings include: R3’s annual Minimum Data Set (MDS) dated 4/24/26 indicated severe cognitive impairment, a mechanically altered diet, supervision or touch assistance for eating, and diagnoses that included gastroesophageal reflux disease (the stomach contents flow backward into the esophagus and may cause difficulty or pain when swallowing), malnutrition, arthritis, and dementia. R3’s care plan indicated the following: 5/7/26 Resident was alert and oriented to person and place with periods of confusion with an intervention to anticipate and meet needs when if resident was unable to express himself. 6/12/26 Resident had a self-care performance and mobility deficit related to cognitive concerns, pain, and osteoarthritis with an intervention to eat independently after set-up, with supervision. 7/23/26 Resident had a nutritional problem or potential nutritional problem with need for nectar-thick liquids due to dysphagia (swallowing disorder) with an intervention to provide nectar-thick liquids. R3’s progress note dated 7/23/26, indicated that R3 returned from the hospital with pneumonia on a dysphagia diet and required supervision with meals. The progress notes diagnoses list further indicated pneumonia due to inhalation of food. R3’s orders indicated the following: 7/15/26 indicated a regular diet with pureed texture and nectar consistency liquids 7/15/26 indicated no straws per family/dysphagia diet R3’s breakfast tray card dated 7/23/26 for breakfast indicated a pureed diet with nectar thick liquids. During an interview on 7/3/26 at 1:23 p.m., the speech language pathologist (SLP)-A stated signs of			20940			08/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
20940	Continued from page 3 aspiration included coughing, a wet vocal quality after swallowing liquids, throat clearing, and shortness of breath. During an interview on 7/23/26 at 4:34 p.m., with the family member (FM)-A stated on 7/23/26 around 9:30 a.m., when FM-A was visiting, a nursing assistant (NA) dropped off R3’s breakfast tray with two cups of liquids that were not thickened and a water pitcher with water that was not thickened with a straw in it. The FM-A stated all R3’s liquids were supposed to be thickened, and R3 was not allowed to use a straw. The FM-A stated she was aware of R3’s dietary restrictions and asked the NA to get some thickener for the water, and the NA left the room and did not return. The FM-A stated she ensured that R3 did not consume any of the liquids provided at breakfast, but if she had not been present, he may have consumed them. During an observation on 7/23/26 at 4:34 p.m., R3’s meal ticket from 7/23/26’s breakfast indicated a pureed diet with nectar thick liquids. R3’s breakfast was sitting on a dresser in the room and contained two glasses of liquid the FM-A identified as water and apple juice that were not thickened. R3’s water pitcher contained water that was not thickened and a straw, but was out of reach of R3, and the FM-A did not allow R3 to use it. During an observation on 7/23/26 at 4:55 p.m., the administrator observed R3’s liquids on the breakfast tray. During an interview on 7/23/26 at 4:55 p.m., the administrator stated she was unsure if he liquids were thickened and thought if they had been thickened, they might get thinner throughout the day but wasn’t sure. The FM-A gave the administrator a description of the NA who dropped off the tray, and the administrator stated she would try to identify the staff based on the schedule. During an interview on 7/24/26 at 11:41 a.m., the NA-C acknowledged she cared for R3 the morning, of 7/23/26, and delivered his breakfast tray to the room and did not know R3’s dietary order specified thickened liquids until the evening of 7/24/26, when the director of nursing (DON) called her to re-educate her about the meal ticket process. The NA-C acknowledged she should have looked at R3’s meal ticket more carefully and had another staff verify the tray was set up correctly but had not. The NA-C stated she had read R3’s meal ticket previously and was unsure when R3’s needs changed to thickened liquids and stated she had			20940			08/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
20940	Continued from page 4 never provided R3 with thickened liquids. The NA-C stated R3 was not supposed to have a water pitcher with a straw, and R3 should have been provided with thickened liquids separately. During an interview on 7/24/26 at 1:13 p.m., the NA-A stated when the NAs passed trays, the NAs were supposed to review the meal tickets and have another staff verify the tray is set up correctly. During an interview on 7/24/26 at 1:23 p.m. the licensed practical nurse (LPN)-A stated when a resident was at risk of aspiration, they required either nectar or honey consistency fluids, could not have a water pitcher in their room, and could not use a straw. If the precautions were not followed, the resident could choke. During an interview on 7/24/26 at 1:41 p.m., the LPN-B stated aspiration precautions included an order for no straw, no water pitcher in the room, and staff had to ensure residents received he fluids of the correct consistency or they could cough or choke. The LPN-B stated she was working 7/23/26 but was not aware R3 received a water pitcher with a straw or the wrong fluids as that would not be safe for R3. During an interview on 7/24/26 at about 4:02 p.m., the DON stated aspiration precautions included staying upright with oral intake, following the ordered liquid consistency and food texture orders, and encourage the residents to stay sitting up for half an hour after meals. During an interview on 7/24/26 at the regional director of clinical services (RDCS)-A stated after she learned R3 received the incorrect liquid consistency on 7/23/26, she implemented orders to listen to lung sounds and perform vital signs every shift for three days to monitor R3's condition. R3 had an SLP evaluation to ensure he the thickened liquid recommendations were appropriate. The RDCS-A stated the facility did not have a policy for aspiration precautions. SUGGESTED METHOD OF CORRECTION: The Registered Dietician (RD) or designee(s) could review and revise as necessary the policies and procedures regarding mechanically altered liquids. The RD or designee (s) could provide training for all appropriate staff on these policies and procedures. The RD or designee (s) could monitor to assure all residents receive the appropriate liquid consistency. TIME PERIOD FOR CORRECTION: Twenty-one (21)			20940			08/17/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER PARK RIVER HEALTHCARE AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9899 AVOCET STREET NORTHWEST , COON RAPIDS, Minnesota, 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
20940	Continued from page 5 days			20940			08/17/2026