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	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Estates Care Center	9899 Avocet Street Northwest Coon Rapids, MN 55433

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083 Based on interview, and document review the facility failed to ensure 1 of 3 residents (R1) remained free of an avoidable accident and injury. This resulted in actual harm when R1 sustained a comminuted distal humeral shaft fracture (upper arm, near the elbow) when R1 was transferred with assistance of one staff and fell into her wheelchair. Findings include: A nursing home incident report (NHIR) submitted to the State Agency (SA) indicated on 3/18/25 at 10:09 a.m. , R1 was transferred from her wheelchair to her bed with assistance of two staff. Resident is a mechanical lift. Shortly after, R1 cried out in pain. R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 had diagnoses of Alzheimer's disease and osteoarthritis. R1's MDS indicated she was dependent for bed to chair transfers and was non-ambulatory. R1's MDS indicated she was cognitively intact. R1's care plan dated 2/10/25, directed resident required assistance of two (A2) staff with mechanical lift with transfers and was unable to ambulate. A facility document, nursing assistant care sheet, directed R1 to be transferred with A2, using the mechanical lift. A physical therapy (PT) discharge plan, dated 1/27/25, directed continue mechanical lift for transfers. R1's task sheet indicated she was transferred with limited assistance on 3/18/25 at 9:33 a.m., using one person (A1) to assist. An x-ray of the right humerus (upper arm), on 3/18/25, indicated comminuted distal humeral shaft fracture (upper arm, near the elbow). (continued on next page)

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.

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

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	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Estates Care Center	9899 Avocet Street Northwest Coon Rapids, MN 55433

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note on 3/18/25 at 10:10 a.m., indicated licensed practical nurse (LPN)-B was notified R1was in her wheelchair and was yelling and holding her right arm. LPN-B and nursing assistant (NA)-A transferred R1 into bed. Resident was pointing to her right arm crying. R1 stated she fell during a transfer. R1's right arm was swollen above the elbow. R1 was not able to move her right arm. X-ray ordered by provider. A progress note on 3/18/25 at 3:00 p.m., new orders for give five milligrams (mg) morphine now, repeat dose of five mg in 30 minutes if no relief. Give morphine five mg by mouth every four hours as needed for pain. A progress note on 3/20/25, written by the nurse practitioner (NP) indicated on 3/18/25, R1 was transferred by two staff members. R1 fell fracturing her right humerus. NP ordered to immobilize right arm in sling. Morphine for pain management. On 3/20/25, at 12:25 p.m., family member (FM)-A stated R1 was alert, responsive, and forgetful at times prior to the incident. FM-A stated R1 was in bed most of the time, but got up into her recliner a few times each day. On 3/20/25 at 1:45 p.m., nursing assistant (NA)-A stated on 3/18/25, she transferred R1 from her bed to her wheelchair, using a gait belt. NA-A stated R1 fell backward into her wheelchair and immediately started to scream in pain, I hurt, I hurt. Help. NA-A described R1's incident as R1 flopped back into the wheelchair. NA-A stated the care sheet included R1's transfer status of mechanical lift and two staff but she did not follow the care plan. NA-A stated LPN-B assisted her to transfer R1 back to her bed, using a gait and A2. On 3/20/25, at 1:56 p.m., the NP stated R1's right humerus fracture was confirmed by x-ray. The NP stated R1's change in condition began after R1's injury. On 3/20/25, at 2:27 p.m., LPN-A stated she was called into R1's room by LPN-A about 30 minutes after the incident. LPN-A stated R1 told her she fell and stated her arm hurt. LPN-A stated R1's right upper arm was swollen and had no range of motion. LPN-A stated she called the NP and received orders for an x-ray and pain medication. On 3/20/25, at 3:12 p.m., LPN-B stated she was called into R1's room on 3/18/25 by NA-A, immediately following the incident. LPN-B stated R1 was in her wheelchair, stating her right arm hurt. LPN-B stated NA-A had transferred R1 out of bed to her wheelchair, using a gait belt, without assistance of another staff person. LPN-B stated she and NA-A transferred R1 back into bed, using a gait belt and pivot transfer. LPN-B stated care plans were listed on the care sheets, including each residents transfer method. LPN-B stated R1 was expected to be transferred with the mechanical lift and A2. On 3/21/25, at 8:32 a.m., the director of nursing (DON) stated she expected the nursing staff to follow the care plans, listed on the care sheets, for the residents. The DON stated R1 was changed to a mechanical lift for transfers several weeks prior due to getting more stiff and for her comfort. The DON stated while R1 mostly remained in her room, she transferred into her recliner one to two times daily and into her wheelchair weekly to obtain her weight. The DON stated the root cause of R1's injury was the care plan was not followed. The mechanical lift was deemed necessary for safe and comfortable transfers. (continued on next page)

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	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Estates Care Center	9899 Avocet Street Northwest Coon Rapids, MN 55433

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/21/25, at 9:15 a.m., the assistant director of nursing (ADON) stated care plans were printed on the care sheets for nurses and NA's. The ADON stated care plans were expected to be followed. He stated R1 had a gradual decline and was changed to an assist of two staff with the mechanical lift for transfers a couple of months prior. The ADON stated R1 was alert and able to communicate prior to the incident. He stated R1 stayed in her room but transferred into her recliner several times throughout the day. On 3/21/25, at 1:59 p.m., NA-B stated R1's transfers were performed with A2 and mechanical lift. NA-B stated this change was recent, in the past month. A facility document, Care Plan Policy and Procedure, dated 2/25, directed the care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible.