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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 501M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00449

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245592**

2.STATE VENDOR OR MEDICAID NO.
(L2) **852108000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAKLAND PARK COMMUNITIES**
(L4) **123 BAKEN STREET**
(L5) **THIEF RIVER FALLS, MN** (L6) **56701**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **9/10/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 01/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 02/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/17/2013
(L33)

DETERMINATION APPROVAL

CCN: 24-5592

A standard OTC survey was completed at this facility on July 19, 2013. The most serious deficiencies were cited at a S/S level of F.

In addition, on August 22, 2013, a FMS survey was completed and deficiencies were found, the most serious at a S/S level of F. On August 29, 2013, CMS notified the facility of the following:

Mandatory DOPNA, effective October 19, 2013.
A loss of NATCEP for a two year period beginning October 19, 2013 if DOPNA were to go into effect.

A PCR of the health deficiencies was completed on September 10, 2013. A PCR of the LSC and FMS deficiencies was completed on October 30, 2013. All of the deficiencies were found corrected. The facility was found in compliance as of October 18, 2013. As a result, we recommended the following to CMS and CMS concurred:

Mandatory DOPNA, effective October 19, 2013, be rescinded.

Since DOPNA did not go into effect, the facility would not be subject to a loss of NATCEP.

See attached CMS-2567B from the revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5592 February 6, 2014

Mr. Tyler Ahlf, Administrator
Oakland Park Communities
123 Baken Street
Thief River Falls, Minnesota 56701

Dear Mr. Ahlf:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 18, 2013 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 21, 2014

Mr. Nicolai Berg, Administrator
Oakland Park Communities
123 Baken Street
Thief River Falls, Minnesota 56701

RE: Project Number S5592022 and F5592023

Dear Mr. Berg:

On August 7, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 19, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

In addition, on August 22, 2013, A surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference the FMS revealed that your facility continues to not be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On August 29, 2013, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 19, 2013 (42 CFR 488.417(b))

On September 10, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 30, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 19, 2013 and a Federal Monitoring Survey (FMS) completed on August 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 18, 2013.

Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 19, 2013 and FMS completed on August 22, 2013, effective October 18, 2013. As a result of the PCR findings, this Department recommended to the CMS Region

V Office the following actions related to the remedies outlined in their letter of May 30, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 19, 2013 be rescinded. (42 CFR 488.417(b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment of new Medicare admissions, effective October 19, 2013, be rescinded. They will also notify the State Medicaid agency that the denial of payment for all Medicaid admissions, effective October 19, 2013 , is to be rescinded.

Correction of the Life Safety Code deficiency cited under K0061at the time of the August 22, 2013 FMS, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of November 15, 2013, has been approved.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245592	A. Building B. Wing	9/10/2013

Name of Facility	Street Address, City, State, Zip Code
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **08/28/2013**
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **08/28/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **08/28/2013**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **08/28/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/28/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/28/2013**	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/LB	01/21/2014	28035	09/10/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/19/2013			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245592	A. Building B. Wing 01 - MAIN BUILDING 01	10/30/2013

Name of Facility	Street Address, City, State, Zip Code
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	09/13/2013	ID Prefix Reg. # NFPA 101 LSC K0056	09/13/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	01/21/2014	03006	10/30/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/17/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245592	A. Building B. Wing **01 - MAIN BUILDING 01**	10/30/2013

Name of Facility	Street Address, City, State, Zip Code
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **10/18/2013**	ID Prefix	Correction Completed **10/18/2013**	ID Prefix	Correction Completed **10/18/2013**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0027	
ID Prefix	Correction Completed **10/18/2013**	ID Prefix	Correction Completed **10/18/2013**	ID Prefix	Correction Completed **10/18/2013**
Reg. # **NFPA 101** LSC K0050		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0056	
ID Prefix	Correction Completed **08/28/2013**	ID Prefix	Correction Completed **10/18/2013**	ID Prefix	Correction Completed **10/18/2013**
Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0069		Reg. # **NFPA 101** LSC K0073	
ID Prefix	Correction Completed **10/18/2013**	ID Prefix	Correction Completed **09/11/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0074		Reg. # **NFPA 101** LSC K0144		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	01/21/2014	03006	10/30/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/22/2013			

Loveland, Jim (MDH)

From:	Suzuki, Jan M. (CMS/CQISCO) <Jan.Suzuki@cms.hhs.gov>
Sent:	Thursday, October 17, 2013 4:24 PM
To:	Loveland, Jim (MDH)
Cc:	Absolon, Mary (MDH); Kerssen, Pam (MDH); King, Maria (MDH)
Subject:	Acceptable POC for Oakland Park Communities, #245592
Attachments:	Scanned_document_17-10-2013_16-07-32.pdf

We have an acceptable POC for the LSC FMS deficiencies (please see attachment).

We approved a Temporary Waiver for K61 through 11/15/13.

Please conduct a revisit per CMS policy.

Thanks,

Jan Suzuki
Principal Program Representative
Centers for Medicare & Medicaid Services
RO V, Chicago
Midwest Division of Survey and Certification
LTC Certification and Enforcement Branch
(P) 312-886-5209
(F) 443-380-6602
jan.suzuki@cms.hhs.gov

FAX to:

Number of Pages: 18

CCN: 245592

Name: Oakland Park Communities

City, State: Thief River Falls, MN

DPNA Date: 10/19/2013

Termination Date: 01/19/2014

FMS Survey Date: 08/22/2013

Fed Surveyor: BWW

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("AW")
E	K18	POC 10/18/13
F	K25	POC 10/18/13
E	K27	POC 10/18/13
F	K50	POC 10/18/13
F	K52	POC 10/18/13
F	K56	POC 10/18/13
F	K61	**TW 11/15/13**
F	K62	POC 8/28/13
F	K69	POC 10/18/13
E	K73	POC 10/18/13
F	K74	POC 10/18/13
F	K144	POC 9/11/13
		Bruce W. Wexelberg

Approved: **YES**

By: Bruce W. Wexelberg

Date: 10/17/2013

Oakland Park
Communities

123 Baken Street • Thief River Falls, MN 56701
Phone: (218) 681-1675 • Fax: (218) 681-1037
Email: opc@oaklandparktrf.com

September 13, 2013

Bruce Wexelberg, Safety Engineer
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Dear Mr. Wexelberg:

Please accept the enclosed Plan of Correction for Oakland Park Communities.

If you have any questions, please feel free to contact me at (218) 681-1675.

Sincerely,

Angela Malone

Angela Malone
Administrator

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/22/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

(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
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 8/22/13 following a Minnesota Department of Health survey on 7/17/13. At this Comparative Federal Monitoring Survey, Oakland Park Community was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Oakland Park Community is a one-story building of Type II (111) construction that was built in 1975. The building is fully sprinklered except where noted under tag K56. There is supervised smoke detection located in the corridors at the cross-corridor smoke barrier doors and at the end of the hall by the unit lounges. Supervised smoke detection is also located in the unit lounges and in the maintenance shop where the fire alarm panel is located. The facility has 40 certified beds. All 40 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 25. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20	K 018		

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

Angela Malone | Administrator | 9/13/13

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.

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 018	Continued From page 1 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide corridor doors that meet the requirements of NFPA 101 - 2000 edition, Sections 19.3.6.3, 19.3.6.3.1 and 19.3.6.3.2. This deficient practice could affect approximately 10 of the 25 residents. Findings include: On 8/22/13 at 2:46pm, observation revealed that the corridor door to soiled utility room 119D was not positive latching. The latch was taped in the retracted position so that the latch did not work. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 018	K018 The lock on Utility Room 119D will be repaired and the tape removed. Staff will be instructed on reporting doors which do not latch and reminded to report to maintenance as soon as discovered. Staff will also be instructed to not put any tape or other material on a door latch to hold it open. Maintenance will do monthly checks to monitor all door handles to assure proper latching. Completion date: October 18, 2013	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at	K 025		

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 025	Continued From page 2 least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.3.2 and 8.3.6. This deficient practice could affect all 25 residents. Findings include: 1. On 8/22/13 at 1:33pm, observation revealed that above the ceiling at the smoke barrier by the business office there were penetrations of a cable, a conduit, a duct and a bar joist that were not properly firestopped. In addition, the top 2" of the wall was filled with fiberglass insulation and was not properly firestopped to the roof deck. 2. On 8/22/13 at 1:34pm, observation above the ceiling at the smoke barrier in the business office there were penetrations of a plastic pipe, a bundle of six to 10 cables, and a conduit were not properly firestopped. In addition, the top 2" of the wall was filled with fiberglass insulation and was not properly firestopped to the roof deck.	K 025	K025 The Administrator called the local building inspector and the facilities architect to confirm current smoke barrier walls and smoke compartments. Four (4) smoke compartments were confirmed and facility floor plan was correct in location of smoke barrier walls. 1. Upon further research, it has been determined the location cited is not a smoke barrier. 2. Upon further research, it has been determined the location cited is not a smoke barrier. 3. Upon further research, it has been determined the location cited is not a smoke barrier. 4. Upon further research, it has been determined the location cited is not a smoke barrier. 5. The smoke barrier in the DON office will be firestopped.	

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 025	Continued From page 3 3. On 8/22/13 at 1:35pm, observation revealed that above the ceiling at the smoke barrier in the medical records office the top 2" of the smoke barrier wall was filled with fiberglass insulation and was not properly firestopped to the roof deck. 4. On 8/22/13 at 1:37pm, observation above the ceiling at the smoke barrier in the physical therapy room revealed that the smoke barrier wall stopped at the bottom of an unprotected steel beam approximately 14" tall. In addition, the 4" gap above the unprotected steel beam that was in the plane of the smoke barrier wall was filled with fiberglass insulation and was not properly firestopped. 5. On 8/22/13 at 1:52pm, observation above the ceiling at the smoke barrier in the corridor by the Director of Nursing's office revealed that the top 2" of the wall was filled with fiberglass insulation and was not properly firestopped. 6. On 8/22/13 at 2:08pm, observation above the ceiling at the smoke barrier in the multipurpose room revealed that an approximately 10' section of the smoke barrier wall consisted of drywall on one side of metal studs only. The exposed metal studs do not have a fire resistance rating. This smoke barrier wall construction does not meet the minimum 1/2-hour fire resistance rating required for a smoke barrier wall in an existing health care occupancy. These deficient practices were confirmed by the Facility Administrator at the time of discovery.	K 025	6. The smoke barrier in the multipurpose room will be fire-stopped by installing sheetrock and chalking. To avoid further misunderstanding of the fire plan in regards to the LSC, the Administrator will revise the Fire Safety Plan and orientate staff to the correct procedures and appropriate smoke compartment location. Maintenance and/or Administrator will review any future work which penetrates the smoke barrier wall will be properly firestopped. I have attached a floor plan from the architect showing the smoke compartments. Completion Date: October 18, 2013	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 027		

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 027	Continued From page 4 Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain doors in smoke barrier walls as required by NFPA 101 - 2000 edition, section 19.3.7, 19.3.7.1, 19.3.7.6, 8.3 and 8.3.4. This deficient practice could affect approximately 10 of the 25 residents. Finding include: On 8/22/13 at 1:40pm, observation revealed that the door to the physical therapy department that was located in the smoke barrier was held open with a device that was not connected to the fire alarm system. The door would not release when the fire alarm system was activated. The door was not always self-closing. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 027	**K027** As explained in K025, it has been determined this is not a smoke barrier wall. Completion date: October 18, 2013	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050		

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 050	Continued From page 5 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills in accordance with the requirements of NFPA 101 - 2000 edition, Section 19.7.1.2. This deficient practice could affect all 25 residents. Findings included: On 8/22/13 at 11:20am, review of the documents titled "Fire Drill Report" for the last 12 months revealed that there was no fire drill conducted on the second shift during the second quarter of 2013. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 050	**K050** The missed June fire drill was performed on 7/12/2013 as soon as it was discovered to be missed, although it was late. Administrator and/or Maintenance personnel, with the help of the Corporate Building and Grounds Director, will monitor that all fire drills are completed in a timely manner. Completion date: October 18, 2013	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 052	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to properly maintain the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 7-3, 7-3.1, 7-3.2, 7-5.2.2 and Figure 7-5.2.2. This deficient practice could affect all 25 residents. Findings include: 1. On 8/22/13 at 11:25am, review of the document titled "Northland Fire Protection Inspection and Testing Form" dated 9/26/12 revealed that the comments section of the report states: "Notification by Asstd [sic] Living and Haven Activity area is non-operational - service required." When asked at the time of the document review if any corrective action had been taken to fix the non-functioning notification devices the Facility Administrator replied, "No." 2. On 8/22/13 at 11:26am, review of the document titled "Northland Fire Protection Inspection and Testing Form" dated 9/26/12 revealed that the fire alarm test and inspection report did not include all of the required information. There was no individual list of initiating devices that were tested. The comment section of the report states: "See device list for location and type of detectors tested." When asked if the facility had the list of smoke detectors	K 052	**K052** Administrator contacted Northland Fire Protection (NFP) to assure the service needed is completed. 1. NFP has been hired to fix the notification problem in the assisted living wing. Administrator has implemented a Temporary Fire Plan for verbally notifying AL clients in the event of fire. 2. NFP has been requested to send a supplemental list of initiating devices tested during their visit on 9/26/12. The Administrator and Corporate Building and Grounds Director have spoken with NFP regarding the documentation needed post inspections. Completion date: October 18, 2013	

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 052	Continued From page 7 that were tested during the 9/26/12 fire alarm system test the Facility Administrator replied, "No." In addition, there are initiating devices other than smoke detectors that need to be tested and included in the list of "Initiating and supervisory device tests and inspections" section of the report. These deficient practices were confirmed by the Facility Administrator at the time of discovery.	K 052	K056 Sprinkler company has been on site to discuss issues and a plan is in place to correct. 1. On August 28, 2013, a sprinkler head was installed in the stairwell to the roof. 2. On August 28, 2013, a sprinkler head was installed in the walk-in freezer. 3. Installation of a sprinkler head in the electrical panel closet 119F has been scheduled. 4. Installation of a sprinkler head in the electrical panel closet 136G has been scheduled. Completion Date: October 18, 2013	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7: NFPA 13 - 1999 edition, Section 5-1.1. This deficient practice could affect all 25 residents. Findings include:	K 056		

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 056	Continued From page 8 1. On 8/22/13 at 1:45pm, observation revealed that the room containing the stair to the roof was not sprinklered. 2. On 8/22/13 at 2:29pm, observation revealed that the kitchen walk-in freezer was not sprinklered. 3. On 8/22/13 at 2:47pm, observation revealed that the electrical panel closet room 119F was not sprinklered. 4. On 8/22/13 at 2:52pm, observation revealed that the electrical panel closet room 136G was not sprinklered. These deficient practices were confirmed by the Facility Administrator at the time of discovery.	K 056		
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72; 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.5, 19.3.5.1 and 9.7. This deficient practice could affect all 25 residents. Findings include:	K 061	K061 The facility is requesting a temporary waiver of K061 due to time constraints to meet LSC requirements. Work will be completed by November 15, 2013. The following work will be completed by November 15: Administrator will work with the sprinkler company and fire protection vendor to install a tamper switch on the post indicator valve and have it electronically monitored at the Fire panel in the facility. Maintenance will monitor the post indicator valve weekly to assure it is open.	

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 061	Continued From page 9 On 8/22/13 at 2:36pm, observation revealed that the post indicator valve in the sprinkler system water supply located outside of the building was not supervised by the fire alarm system. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 061		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain its automatic sprinkler system in accordance with NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFPA 25 - 1998 edition, Sections 2-2, 2.2.1.1 and 2-4.1.4. This deficient practice could affect all 25 residents. Findings include: On 8/22/13 at 2:27pm, observation revealed that there were not two sprinklers of each type used in the facility kept on site. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 062	**K062** The side-wall sprinkler in question was replaced on August 28 due to the age of the current sprinkler and to coordinate with the new sprinkler placed in the stairwell to the roof. The sprinkler company left 2 spares in the sprinkler head box. Maintenance will annually or upon repair of a sprinkler, inventory sprinkler heads on hand to assure there appropriate number of replacement heads. Completion date: August 28, 2013	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/22/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

(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
K 069	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to install the kitchen range hood fire extinguishing system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 96 - 1998 edition, Sections 7-4.1 and 8-2. This deficient practice could affect all 25 residents. Findings include: 1. On 8/22/13 at 11:51am, review of the documents titled "Northland Fire Protection, Suppression Fire System Inspection & Maintenance Report" dated 4/16/13 and 10/9/12 revealed that the kitchen range hood system was not inspected at least every six months. 2. On 8/22/13 at 2:32pm, observation revealed that there was no automatic fuel shut off valve connected to the kitchen range hood system. These deficient practices were confirmed by the Facility Administrator at the time of discovery.	K 069	**K069** The kitchen range hood was inspected on October 9, 2012 and again on April 16, 2013, but not within 6 months so the facility was 7 days late. Administrator and Corporate Building and Grounds Director have spoken to Northland Fire (fire protection company) and discussed this detail with them to avoid future discrepancies. Maintenance and/or Administrator will monitor and schedule kitchen range hood inspections within 6 months of the prior inspection.	
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility was free of combustible decorations in accordance with NFPA 101 - 2000 edition, Section 19.7.5.4. This	K 073	Documentation was located regarding an automatic fuel shut off in the kitchen. Administrator will make sure staff is aware of the shut off and its location. Completion date: October 18, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/22/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	**123 BAKEN STREET THIEF RIVER FALLS, MN 56701**

(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
K 073	Continued From page 11 deficient practice could affect approximately 10 of the 25 residents. Findings include: On 8/22/13 at 3:55pm, observation revealed that three candles with burnt wicks were used for decoration in room 132. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 073	**K073** The Administrator will talk to the resident and her family and request the candle be removed from the facility.	
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 074	Upon admission to the facility, the admissions person will instruct residents and/or families that no candles or wick containing decorations are allowed within the facility. Staff will be trained in this rule and instructed to report any candles or wick containing decorations to Administration or Maintenance for removal from the facility. Completion date: October 18, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/22/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

(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
K 074	Continued From page 12 failed to provide drapery materials meeting the requirements of NFPA 101 - 2000 edition, Sections 19.7.5.1 and 10.3.1. This deficient practice could affect all 25 residents. Findings include: On 8/22/13 at 2:44pm, observation revealed that all of the resident rooms had fabric draperies. An interview with the Facility Administrator during the document review portion of the survey revealed that the facility did not have any flame spread information on the draperies. Observation of the draperies in a random sample of resident rooms revealed that the draperies did not have any labels indicating their fire retardant nature. When asked if he know what the fire retardant nature of the material was the Facility Administrator replied, "No, I do not."	K 074	**K074** The curtains without flame spread labels were sprayed with flame retardant and documented in the flame retardant binder. All new furnishings and or fabric materials will be scanned to assure proper labeling or sprayed with flame retardant and process documented in the flame retardant binder. Completion date: October 18, 2013	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct monthly load tests of the emergency generator in accordance with the requirements of NFPA 101 - 2000 edition,	K 144	**K144** After survey, information from the generator company was located in the generator binder. Documentation from the company states "...standard operating temperature at full load should be 180-190 degrees ...It will be lower depending on the ambient temperature and	

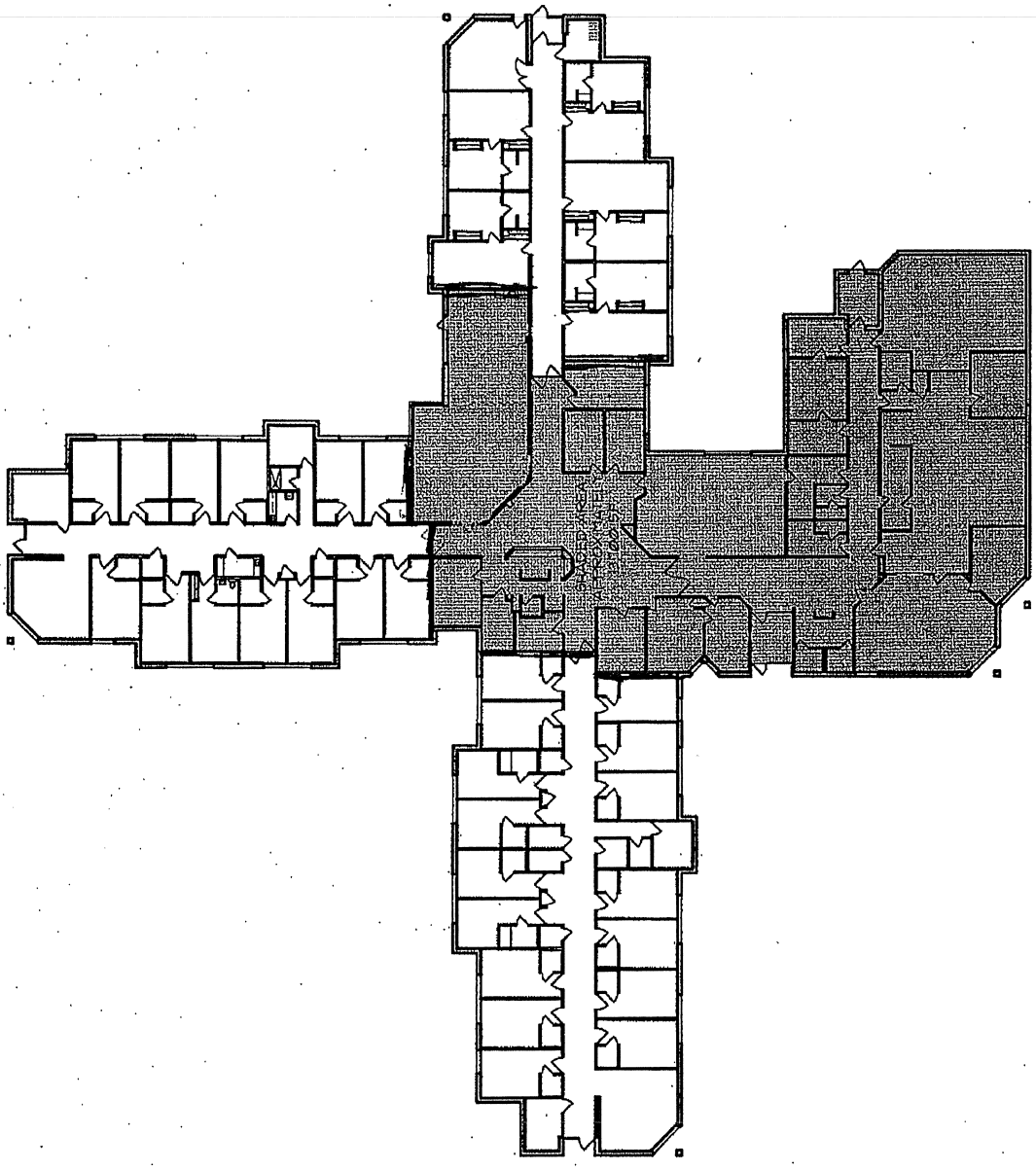
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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
K 144	Continued From page 13 sections 19.5.1 and 9.1.3 section 6-4.1 and 6-4.2. This deficient practice could affect all 25 residents. Findings include: On 8/22/13 at 12:04pm, review of the document titled "Oakland Park Communities Emergency Generator - Monthly Test Log" for the last 12 months revealed that the monthly load tests for the emergency generator were not at 30% of the name plate rating. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 144	reduced load. An estimate of 150-160 degrees operating temp is likely if you are only 30% loaded." Documentation from the last year of monthly tests shows operating temps ranging from 160 degrees (once) to 180 degrees. Monthly, the facility will verify the generator runs at more than 150 degrees for at least 30 minutes based on the documentation from the generator company. I have attached a copy of the company's documentation. Completion date: September 11, 2013	



OVERALL FLOOR PLAN

NTS

OAKLAND PARK
09/24/2013

ZIEGLER Power Systems CAT

Fax

To	Leanne Olson	Date	05/26/2011
Company/Department	Oakland Park	From	Doug Eckerman
Fax	218 681 1037	Phone	952 887 4535
Number of pages (including cover)	1	Fax	952 233 4622
Re	D50P3 Generator		

Hi Leanne,
I spoke to our service department and they advised standard operating temperature at full load should be 180 – 190 degrees with a full load on your D50P3 (4.4 liter engine).

It will be lower depending on the ambient temperature and reduced load. An estimate of 150 – 160 degrees operating temp is likely if you are only 30% loaded.
Regards.
Doug

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 501M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00449

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245592**
2.STATE VENDOR OR MEDICAID NO.
(L2) **852108000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAKLAND PARK COMMUNITIES**
(L4) **123 BAKEN STREET**
(L5) **THIEF RIVER FALLS, MN** (L6) **56701**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/19/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the Standard survey completed July 26, 2013, the facility was not in substantial compliance with Federal certification regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NEII 09/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 9/17/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5100

August 7, 2013

Ms. Angela Malone, Administrator
Oakland Park Communities
123 Baken Street
Thief River Falls, Minnesota 56701

RE: Project Number S5592022

Dear Ms. Malone:

On July 19, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 19, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number .

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 19, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkmann
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601

Telephone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 16, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 16, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 19, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

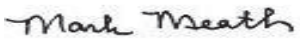
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5592s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____ RECEIVED AUG 19 2013	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKER STREET THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157	F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) R41's physician was notified on 7/14/2013 of decline in condition when he came out on rounds with a ten minute notice that he was rounding. R41 did not experience any change in condition that required notification of the physician	8/23/13 DOC DK c/A P932 LB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela McCune — TITLE: Administrator — (X6) DATE: 8/15/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 157	Continued From page 1 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the physician of a decline in health condition for 1 of of 1 (R41) resident reviewed. Findings include: R41's diagnoses included a stroke, left sided weakness, depression, hypertension and coronary artery disease. The Brief Interview for Mental Status (BIMS) dated 5/22/13, indicated R41 was cognitively impaired. R41's Minimum Data Set (MDS) dated 5/22/13, indicated R41 required extensive assist with bed mobility, transfering, toileting, personal hygiene and set up assistance with eating. The MDS also indicated R41 had mild discomfort. The Care Area Assessment (CAA) dated 5/22/13, indicated R41 had an increase in behavioral issues such hitting and calling out to staff which came and went with periods of confusion. The Nutrition CAA dated 5/22/13, indicated R41 was a risk for choking and	F 157	until 7/17/2013 on the day he expired. Physician and family were notified of resident's expiration. Any identified resident experiencing a change in condition will be addressed per regulation. Any resident change of condition will be addressed during nurse report at change of shift daily. All appropriate staff will be re-educated on notification of family/physician for changes per regulation. Audits will be done randomly as any change occurs that requires notification to ensure appropriate notification was complete timely x3 months and then report to QA for further recommendations. Audits will be completed by DON and/or designee. Completion date: 8/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 157	Continued From page 2 aspiration and had shown a decline in condition. R41's Code Level Order for Cardiopulmonary Resuscitation form dated 4/2/13, indicated R41 requested no interventions be made in the event his heart would stop or he would stop breathing. The physician progress note dated 7/14/13, indicated R41 had shown significant deterioration in that R41 would wake up and move, but wasn't talking or taking oral medication. The note further indicated the plan was to provide R41 comfort cares only and directed staff to hold all oral medications unless normal level of alertness. The physician order dated 7/14/13, directed staff to hold all oral medications, unless normal level of alertness returned. The nursing progress notes (PN) indicated the following: -7/14/13, at 11:45 a.m. indicated the physician had made rounds and had placed an order to hold all oral medications unless normal level of alertness. -7/16/13, at 10:00 a.m. indicated R41 was unresponsive, color was pale, skin was cool, clammy and he had rapid breathing. -7/16/13, at 4:00 p.m. indicated R41 remained unresponsive, skin cool and clammy to touch. -7/17/13, at 12:15 a.m. indicated R41's breathing rate had increased and his respirations were gurgling. The note also indicated R41 was not responding to commands, but was raising his right arm. -7/17/13, at 3:45 a.m. indicated R41 was using	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 157	Continued From page 3 more chest muscles to assist him with breathing and was was moaning with repositioning. The note also indicated R41 had no urine output. On 7/17/13, at 7:10 a.m. R41 was observed in bed, dressed, positioned on his left side and moving his right arm in the air. At 8:05 a.m. nursing assistant (NA)-A and NA-B entered R41's room and observed R41 unresponsive and without respirations. NN entry dated 7/17/13, at 8:10 a.m. indicated R41 had expired. On 7/18/13, at 9:59 a.m. the director of nursing (DON) stated she was unaware if the physician had been notified of R41's continued deterioration following his visit on 7/14/13. At 1:20 p.m. licensed practical nurse (LPN)-A stated she was planning on updating the physician on R41's continued deterioration in status on 7/17/13, however, stated she had not. The facility's Notification of Family and Physician Policy and Procedure directed staff to notify the physician as soon as possible with any significant change in a resident's physical condition including deterioration in health.	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.	F 167	F167 RIGHT TO SURVEY RESULTS – READILY AVAILABLE On 7/19/13, Director of Nursing put K-tags and licensing orders from 4/13/12 in the survey book. Administrator will audit book for placement and content monthly to assure it is readily accessible in the future.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 167	Continued From page 4 their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the required State licensing order's and fire marshall K-tag results from the State agency's health survey conducted on 4/13/12. This practice had the potential to affect all 26 residents residing in the facility. Findings include: During the environmental tour on 7/18/13, at 8:15 a.m. with the director of nursing (DON), a three ring binder was observed in the designated day room that contained the most recent survey results dated 4/13/12. However, the binder did not include the State licensing orders or fire Marshall K-tags issued at the time of the 4/13/12, survey. At the time of the observation the DON verified the findings and stated the State licensing orders and fire marshall K-tags should also be posted. In addition, the DON stated the facility did not have a policy and procedure related to the required postings.	F 167	Administrator will report audit findings to QA quarterly for one year. Completion Date: August 28, 2013	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 244	Continued From page 5 grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to resolve resident grievances in regards to housekeeping services for 4 of 7 monthly resident council meeting minutes reviewed for resident council. Findings include: Review of the Resident Council meeting minutes identified: -1/14/13, meeting minutes indicated residents stated their rooms appeared dirty with "dust bunnies" under their beds. The minutes also indicated the concern would be taken to the administrator on the residents behalf. -4/8/13, meeting minutes indicated the residents stated their rooms were not being cleaned weekly and the floors were dirty. The minutes also indicated the concern would be brought up at the next managers meeting. -5/13/13, meeting minutes indicated the residents stated their room floors appeared dirty. The minutes also indicated the residents were informed that the room floors appeared dirty even after they were mopped.	F 244	F244 LISTEN/ACT ON GROUP GRIEVANCE/ RECOMMENDATION Activity Director reviewed grievances with Resident Council on 8/12/13. A couple residents still felt floors appeared dirty so a "Resident Council Concern Form" was completed and given to the Administrator (Housekeeping Supervisor) on 8/13/13. A new policy and procedure relating to the utilization and follow-up of the "Resident Council Concern Form" was created and distributed to all department managers and posted in the staff break room. The Activity Director reviewed the new policy and form with the Resident Council President on 8/13/13. The RC President	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 244	Continued From page 6 -7/8/13, meeting minutes indicated residents voiced concern about their rooms not getting a "total" cleaning and that there was dirt and dust around the windows and the ridge of toilet a toilet seat was dirty. The minutes also indicated their concern would be taken to the housekeeping department head. On 7/18/13, at approximately 8:30 a.m. the director of nursing stated she was unaware of any resident / resident council concerns regarding housekeeping services. At 9:33 a.m. the social service designee (SSD) / resident council lead verified she was aware of the ongoing resident concerns related to housekeeping services. The SSD stated she had informed the department heads of the repeated concern, however, stated the concern remained. In addition, the SSD stated more staff training on housekeeping services was needed. At 10:30 a.m. during a telephone interview, the facility ombudsman verified she had received a resident complaint regarding the lack of housekeeping services. The ombudsman stated the complaint indicated feces had remained on toilet seats and a wall for several days without being cleaned. At 1:22 p.m. during a telephone interview, the administrator verified she was in charge of the housekeeping services. The administrator stated other than spot checks, there was no direct monitoring and supervision of the housekeeping services. In addition, the administrator stated the nursing aides had been instructed to clean resident rooms weekly and in between as	F 244	voiced agreement with the form and policy and procedure. All Resident Council Concern Forms with responsive action will be reviewed by QA quarterly. Completion date: 8/28/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 244	Continued From page 7 needed. At approximately 3:00 p.m. the director of nursing stated the facility did not have policy and procedures related to housekeeping services or resolution to resident council grievances.	F 244	F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically related social services related to the end of life needs and psychosocial well being of 1 of 1 (R41) resident in the sample. Findings include: R41's diagnoses included a stroke, left sided weakness, depression, hypertension and coronary heart disease. The significant change Minimum Data Set (MDS) dated 5/22/13, indicated R41 had severe cognitive impairment and required extensive assist with bed mobility, transferring, toileting, personal hygiene and set up assistance for eating. The MDS also indicated R41 had mild discomfort. The Care Area Assessment (CAA) dated 5/22/13, indicated R41 had an increase in behavioral issues and an	F 250	R41 was seen by his primary physician on 5/22/13 and started on medications due to threats and wanting to end his life which physician states has been present for many years and "he has gotten away with it". Physician also states resident to talk to him or his family and not take it out on the facility staff. R41's wife visited multiple times daily as well as the surrogate daughter several times per week. R41 interacted with staff in varying ways throughout the day from negative behavior to positive. R41 was seen by physician on 7/14/13 and order for comfort cares and hold meds received. Family and wife were aware of this. R41's condition did not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 250	Continued From page 8 increase in depressive symptoms. The Code Level Order for Cardiopulmonary Resuscitation form dated 4/2/13, indicated R41 had requested no interventions be made in the event his heart would stop or he would stop breathing. The Social History Data Sheet [undated] revealed all of R41's siblings were deceased, he was married with a spouse and they had no children. The sheet also indicated R41 was Catholic and attended church. The Nurse's Notes (NN) dated 5/3/13, at 9:10 p.m. indicated R41 kept repeating over and over again "I wish I were dead," " I should just die," "you should just kill me." The Social Service Progress Record dated 5/22/13, indicated had an increase of behaviors as noted on the behavior documentation sheet. The NN dated 6/9/13, at 8:00 a.m. indicated R41 stated "I want to die and no one will let me" and also indicated R41 had requested for his wife to be brought to his room. The note further indicated R41 kept on repeating the Lord's Prayer over and over in English and Norwegian. The next social service note entry dated 6/24/13, indicated R41 had no complaints, was adjusting to the facility, had no present plans of discharge and weekly social service visits had occurred from 6/10/13, to 6/24/13. The physician progress note dated 7/14/13, indicated R41 had shown significant deterioration	F 250	improve and he passed away on 7/17/13. Family and wife were given privacy and visited daily during his decline. All residents with identified individual psychosocial and/or end-of-life needs will be identified on individual care plans with follow through by SSD. All appropriate staff will be educated on psychosocial well-being and end-of-life needs. Audits of psychosocial and/or end-of-life needs will be completed to ensure identified needs are being met and/or adjusted as needed. These will be done weekly x4 on 5 random residents then bi-monthly x2, with reports to QA for further recommendation. Completion date: 8/28/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 250	Continued From page 9 in that R41 would wake up and move, but wasn't talking or taking his medicine. Therefore, the physician directed staff to hold all oral medications unless normal level of alertness returned and to provide comfort cares only. The NN dated 7/14/13, at 11:45 a.m. revealed the physician had made rounds and had placed an order to hold all oral medication. The note also indicated R41 was unresponsive, color was pale, skin was cool, clammy and he had rapid breathing. Throughout observations from approximately 8:00 a.m. until 4:30 p.m. on 7/15/13, and 7/16/13, R41's spouse was observed frequently sitting with R41 or sitting alone in the facility common area next to the nurses' station. On 7/16/13, an attempt to interview R41's spouse was made, however, quickly aborted due to her emotional upset, crying and increased concern about R41's condition. Throughout the survey, the social service staff was not observed making any contact with R41 or his spouse. The NN dated 7/16/13, at 4:00 p.m. indicated R41 remained unresponsive, skin cool and clammy to touch. On 7/17/13, at 7:10 a.m. R41 was observed in bed, dressed, positioned on his left side and moving his right arm in the air. At 8:05 a.m. on 7/17/13, nursing assistant (NA)-A and NA-B observed R41 unresponsive and without respirations. The NN dated 7/17/13, at 8:10 a.m. indicated	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 250	Continued From page 10 R41 had expired. On 7/17/13, at 12:34 p.m. social service designee (SSD)-B verified she was informed of R41's decline in condition on 7/15/13. SSD-B stated normally she would speak to the family and offer them support group information, however, stated she had not spoken with R41's spouse regarding end of life care. SSD-B also stated she had been having weekly informal visits with R41 during passings in the hallways or while R41 was in the dining room, however, SSD-B stated R41 was grumpy and no longer wanted to talk with her, therefore those visits were stopped. Additionally, SSD-B stated she did not always document the brief weekly encounters in the medical record. SSD-B also revealed she had not had much contact with R41's spouse nor had she attempted to build a rapport with her due to the spouse's difficulty communicating related to a significant hearing impairment and use of an eraser type communication board. SSD-B verified psychosocial needs for R41 and his family was an important part of end of life and care and something she should have offered and been involved in. At 2:48 p.m. the director of nursing (DON) stated the social services department was expected to be able to identify, monitor and address resident psychosocial needs for each resident. The DON also stated during end of life care, social services was also expected to provide comfort to the resident and family as needed. At 2:57 p.m. SSD-B confirmed R41's plan of care (POC) did not address his psychosocial needs. SSD-B stated the POC's are to be updated	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 250	Continued From page 11 quarterly and with any significant changes in status. SSD-B confirmed R41's POC should have been updated. On 7/18/13, at 8:02 a.m. SSD-A stated R41 was strong in his Catholic faith with twice monthly visits from the priest. SSD-A confirmed the priest had been notified following R41's death, however she was unaware if the priest had been notified when R41's condition had begun to decline. SSD-A verified she had not attempted to visit R41. At 9:14 a.m. SSD-B confirmed she had attempted to speak with R41 on 7/15/13, however stated he was unable to communicate. SSD-B also confirmed R41's spouse was not offered the option of requesting the priest to come visit during R41's declining condition. At 9:47 a.m. the DON indicated she had contact with R41 and his wife on 7/16/13 and 7/17/13. The DON also confirmed she had not asked R41's wife if she wanted to have the priest called to come for a visit. The DON again confirmed the expectation of the SSD's to be involved in and address the emotional and psychosocial needs, as well as to provide support to the resident and the family during the end of life process.	F 250		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 274	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive reassessment related to a significant improvement in status for 1 of 1 (R32) resident with an identified improvement in activities of daily living (ADL), cognition and bowel and bladder continency. Findings include: R32's diagnoses included anxiety and dementia. The admission Minimum Data Set (MDS) dated 3/13/13, indicated R32 had severe cognitive impairment and required extensive staff assist for bed mobility, transferring, walking, dressing, toileting and personal hygiene. The MDS also indicated R32 was frequently incontinent of urine and occasionally incontinent of bowel. The quarterly MDS dated 6/10/13,indicated R32 had moderate cognitive impairment, was independent with ADL's and was continent of bowel and bladder. The Activities of Daily Living (ADLs) Care Area Assessment dated 3/13/13, indicated R32 required extensive staff assist with all ADL's except eating. On 7/18/13, at 8:48 a.m. the director of nursing (DON) verified she completed all MDS assessments. The DON also verified R32's significant improvement in status and stated a complete comprehensive reassement should have been completed. Policy and procedures were requested and not provided.	F 274	F274 COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE R32 had a significant change completed related to improvement on 8/7/2013. All other resident's identified with a significant change will be addressed per RAI manual instructions. All appropriate staff will be re-educated on significant changes. Audit of residents will be done per OBRA assessments and as needed weekly x3 months and then report to QA for further recommendations. Audits to be completed by DON and/or designee. Completion date: 8/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the assessment accurately reflected the dental status for 1 of 1 (R45) resident reviewed with dental needs. Findings include:	F 278	F278 ASSESSMENT ACCURACY/COORDINATION S/ CERTIFIED R45's dental status was identified on MDS, CAAS, and Care plan on 7/24/2013. He was offered dental services by SSD on 7/18/2013 and again on 8/15/2013 in which he refused services. All residents upon admission will have dental status addressed. Initial dental status will be addressed on initial comprehensive skin assessment form. Dental status will be reviewed quarterly and as needed after that. All appropriate staff will be educated of identifying dental status and documenting. Audits will be done on all admissions, quarterly according to OBRA assessment and as needed to ensure dental status is documented appropriately	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 278	Continued From page 14 R45 had missing and loose lower teeth and the facility failed to assess the need for a potential dental referral. On 7/16/13, at 9:38 a.m. R45 stated he had an upper plate and only eight lower teeth. R45 stated those teeth are never brushed because they are loose and could fall out. The resident denied pain or any problems eating or chewing. R45's diagnosis included a stroke with weakness. The admission Minimum Data Set (MDS) dated 6/21/13, indicated R45 had intact cognition and required extensive staff assistance for bathing, dressing and grooming. The MDS also indicated R45 had no dental problems. The Admit Comprehensive Nursing Assessment dated 6/17/13, indicated R45's eyes, ears, nose, mouth and throat were all clear-no redness or lesions noted. The assessment did not identify any missing or loose teeth. On 7/18/13, at 1:50 p.m. the director of nursing (DON) stated she had completed the admission MDS without actually looking in R45's mouth. The DON verified the MDS dental assessment was not accurate. Policy and procedures were requested and not provided.	F 278	and then report to QA for further recommendation. Audits to be completed by DON and/or designee. Completion date: 8/28/2013	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F282 SERVICES BY QUALIFIED PERSON/PER CARE PLAN R12's incontinence care plan has been reviewed with staff which continues as documented without change. All resident's incontinent care needs will be identified on the plan of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 282	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide incontinence care every two-three hours as the plan of care (POC) directed for 1 of 1 (R12) resident reviewed for incontinence needs. Findings include: R12's diagnoses included dementia, cerebral vascular accident with right sided weakness, above the knee amputation (AKA) and history of recurrent urinary tract infections. The quarterly Minimum Data Set (MDS) dated 5/27/13, indicated R12 had a memory deficit with severely impaired decision making skills. The MDS also indicated R12 required assistance of two staff for transfers and was frequently incontinent of urine. The plan of care (POC) dated 6/11/13, indicated R12 was frequently incontinent of bladder and was dependent on staff with toileting needs. The POC directed two staff to check R12's incontinent product every 2-3 hours and change as needed. On 7/17/13, at 7:00 a.m. R12 was observed in bed, fully dressed with pants on. At 8:15 a.m. R12 was observed to be assisted out of bed by nursing assistant (NA)-A and NA-D. R12's brief was not checked. At 10:30 a.m. R12 was observed to be assisted back to bed by NA-A and NA-D. At that time R12's brief was wet with a strong urine smell. Both NA's verified the findings.	F 282	All appropriate staff will be educated on following each resident's identified care plan related to incontinence cares and timeliness. Audits to be completed on 3 random residents to ensure incontinence care is completed according to care plan weekly x4, bi-monthly x2, then report to QA for further recommendations. Audits to be completed by DON and/or designee Completion date: 8/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 282	Continued From page 16 At approximately 10:45 a.m. NA-D stated the night shift washed and dressed R12 but was not sure what time it would have been done. NA-D verified R12's brief was not checked when assisted out of bed for breakfast at 8:15 a.m. and that when R12 was changed at 10:30 a.m. she was incontinent of urine. NA-D verified it had been three hours and 30 minutes On 7/18/13 at 1:50 p.m. the director of nursing (DON) verified the POC directed staff to assist with incontinence care every two-three hours and stated 3.5 hours was too long. The DON verified the POC was not followed.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely incontinence care on 7/17/13, for 3.5 hours for 1 of 1 (R12) resident who required every two to three hour assistance for incontinence needs.	F 315	F315 NO CATHETER, PREVENT UTI, RESTORE BLADDER R12's incontinence care plan has been reviewed with staff which continues as documented without change. All resident's incontinent care needs will be identified on the plan of care. All appropriate staff will be educated on following each resident's identified care plan related to incontinence cares and timeliness.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 315	Continued From page 17 Findings include: R12's diagnoses included dementia, cerebral vascular accident with right sided weakness, above the knee amputation and history of recurrent urinary tract infections. The quarterly Minimum Data Set (MDS) dated 5/27/13, indicated R12 had a memory deficit, had severely impaired decision making skills, required total assistance of two staff for transfers and was frequently incontinent of urine. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 3/6/13, indicated R12 recently had an above the knee amputation and had an indwelling catheter. The Urinary Incontinence Management Evaluation updated on 5/20/13, noted R12 was frequently incontinent of urine, staff to check every 2-3 hours and change as needed. The plan of care (POC) dated 6/11/13, identified R12 as frequently incontinent of bladder and occasionally incontinent of bowel and was dependent with toileting. The POC directed two staff to check R12's incontinent product every 2-3 hours and change as needed. The POC also directed staff to use the bed pan as needed. On 7/17/13, at 7:00 a.m. R12 was observed in bed, fully dressed with pants on. At 8:15 a.m. nursing assistant (NA)-A and NA-D was observed to assist R12 out of bed. R12's pants were not removed and the brief was not checked. At 10:30 a.m. NA-A and NA-D was observed to	F 315	Audits to be completed on 3 random residents to ensure incontinence care is completed according to care plan weekly x4, bi-monthly x2, then report to QA for further recommendations. Audits to be completed by DON and/or designee Completion date: 8/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 315	Continued From page 18 assist R12 back into bed with use of the mechanical lift. At that time R12's brief was observed wet with a strong urine smell. Both NA's verified the findings. At approximately 10:45 a.m. NA-D stated the night shift washed and dressed R12 but she was not sure what time it would have been. NA-D verified R12's brief was not checked when assisted out of bed for breakfast at 8:15 a.m. and that when she was changed at 10:30 a.m. she was incontinent of urine. On 7/18/13, at 1:50 p.m. the director of nursing (DON) verified the POC directed staff to assist R12 with incontinent cares every two-three hours. The DON confirmed the POC was not followed as directed and stated 3.5 hours was too long of a time span in between cares.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 325	F325 MAINTAIN NURTION STATUS UNLESS UNAVOIDABLE R30 was offered several different types of supplementations on 7/16 and 7/17 which caused her to have episodes of diarrhea and she refused further supplementation including boost which the facility obtained for her. She stated "I do not want to take anything – I remember now how the boost didn't agree with me before". Also addressed by the Dietitian. Resident declined and expired on 7/27/13. Any resident identified with an anticipated nutritional decline will be offered appropriate nutritional supplementation related to need and preference.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 325	Continued From page 19 review, the facility failed to ensure a resident with anticipated nutritional decline received nutritional supplementation according to the assessed need and preference in order to minimize weight loss for 1 of 3 (R30) residents reviewed. Findings include: R30's diagnoses included terminal pancreatic carcinoma, Crohn's colitis, congestive heart failure, nausea, anxiety and anemia. R30 was receiving hospice services. The admission Minimum Data Set (MDS) dated 5/17/13, indicated R30 had intact cognition, was independent with eating and weighed 103 pounds. The Nutrition Care Area Assessment (CAA) dated 5/7/13, indicated R30 was independent with eating, had a malignant neoplasm of pancreas with risk factors of unmet needs and decline in overall condition. The plan of care (POC) dated 5/22/13, indicated R30 was in need of a regular bland diet related to Crohn's disease and was able to request food preferences as needed. The 5/4/13, registered dietitian (RD) note indicated R30's current weight was 103 pounds, received a regular diet as tolerated, current intake was 75% and had a potential for an unavoidable decline due to advanced age and terminal diagnosis. The 5/24/13, Nutritional Assessment Data Collection Form, completed by the Hospice RD indicated R30 was 62 inches tall and weighed	F 325	All appropriate staff will be educated on appropriate nutritional supplementation. Audits will be done after admission, quarterly and as needed to ensure appropriate nutritional supplementation according to need and preference has been addressed and then report to QA for further recommendation. Audits to be completed by Dietary Manager and/or designee. Completion date: 8/28/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 325	Continued From page 20 103 pounds. The 6/3/13, dietary progress note (PN) directed staff to provide comfort and food according to R30's preferences. The 6/23/13, Hospice Recertification form completed by the Hospice registered nurse (RN) indicated R30 had a limited life expectancy of six (6) months or less, had a terminal diagnosis of pancreatic cancer, had continued nausea, pain, weight loss of 9 # since admit to Hospice and continued to decline. The 7/16/13, Hospice RN progress note indicated R30 reported a poor appetite and specifically requested the Boost brand supplement. The note further indicated the Hospice RN had relayed to the director of nursing (DON) that R30 had requested Boost. However, the DON stated the facility only carried the Ensure brand as a supplement, therefore did not provide it. On 7/16/2013, at 8:32 a.m. RN-A verified R30 did not receive a nutritional supplement. RN-A stated R30 had not accepted a supplement. However, no documentation was noted in the medical record. On 7/16/13, at 10:00 a.m. R30 was observed sitting in her recliner, visiting with her daughter. R30 verified she had not received supplements, however, stated she used to drink the Boost brand supplement at home.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 325	Continued From page 21 On 7/16/13, at 11:05 a.m. the Hospice RN stated she had talked with R30 that morning and R30 had stated to her that she used to drink Boost at home and was able to tolerate it. The Hospice RN stated the DON had informed her the facility only offered the Ensure brand supplement. On 7/17/13, at 1:45 p.m. nursing assistant (NA) -B confirmed R30 had a poor appetite. On 7/17/13, at 2:05 p.m. the DON stated the dietitian and dietary manager (DM) were responsible to discuss nutritional supplements with each resident. However, stated the DM had resigned and the dietitian was currently unavailable. Additionally, the DON stated the dietitian was responsible to recommend a supplement and had not recommend one for R30 due to receiving comfort cares. On 7/18/13, at 1:30 p.m. the DON again stated she thought the dietitian had not offered R30 a supplement due to hospice services and provision of comfort cares only. The DON verified the facility had not offered or considered R30's personal request for nutritional supplementation and stated they should have. In addition, the DON stated the facility would be ordering the Boost brand supplement for R30 as well as attempt other supplements as R30 tolerated.	F 325		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 334	Continued From page 22 The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 334	F334 INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS R9's daughter reported that resident had her pneumococcal vaccine upon admission. Spoke with the daughter regarding this and she reports that she could have had it when she was at another nursing home from 1997-2002 or prior when she lived in Canada. Received confirmation from previous nursing home that they had no record of pneumococcal vaccination. Fax was sent to her physician on 7/30/2013 with all of above information and questioned if he wanted to revaccinate with the pneumococcal vaccine and his reply was "no Need". R20 continues to insist that she received the pneumococcal vaccine several years ago. Contact has been made with previous health facility's she has been a patient at, without	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 334	Continued From page 23 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure confirmation of pneumococcal vaccinations given for 2 of 5 residents (R9, R20) and also failed to complete the appropriate documentation of administration for the influenza vaccinations for 2 of 5 residents (R9, R20) as required. Findings include:	F 334	proof of vaccination found. Fax was sent on 7/30/2013 to her physician regarding this and returned with notation to be addressed by Dr. S. Patel when he returns 8/12/2013. Information was re-faxed on 8/13 and 8/14/13 due to no reply, and a phone call made 8/15/2013 regarding this. Received a phone call with telephone order that no record found, administer pneumovax if resident wants it. Spoke with R20 and she wishes to have the vaccine. Will receive pneumococcal vaccine once consent obtained from family. R9, R20 have had a copy of the log for influenza vaccine attached to their consent forms. All residents will be offered the influenza and pneumococcal vaccines per regulations with proper documentation. SSD has also been set up to access MIIC to assist with confirming vaccination dates.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 334	Continued From page 24 R9 was admitted to the facility on 4/30/2012, with diagnosis of Alzheimer's disease The Adult Vaccine Administration Record signed by R9's family member dated 4/30/12, lacked documentation of the date R9 had previously received the pneumococcal vaccination. On 7/17/13, at 2:18 p.m. the director of nursing (DON) revealed the Minnesota Immunization Information Connection (an immunization data base) did not have on record that R9 had ever received a pneumococcal vaccination. R20 was admitted to the facility on 6/27/12, with diagnosis of diabetes. The Adult Vaccine Administration Record signed by R20's family member dated 10/20/12, lacked documentation that R20 had previously received the pneumococcal vaccination. On 7/18/13, at 9:39 a.m. the DON stated she was unable to confirm R9 and R20's pneumococcal vaccination history. The DON provided her Oakland Park Communities Influenza Control Program log for October 2012 [not a permanent part of the medical record]. This log indicated R9 and R20 received influenza vaccinations on 10/31/12. R9's Adult Vaccination Administration Record signed 10/23/12, and R20's Adult Vaccination Administration Record signed 10/20/12, was lacking the documentation on the bottom of the form for when the vaccination was administered, lot number, site of injection/route and the signature of person who administered the vaccination.	F 334	All appropriate staff will be educated on regulations for influenza/pneumococcal vaccinations. Audits will be completed with admissions and annual vaccination to ensure proper documentation is in place, then report to QA for further recommendations. Audits to be completed by DON and/or designee. Completion date: 8/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 334	Continued From page 25 The facility's Influenza/Pneumococcal Immunization Policy and Procedure revised date 2/2012, indicated all residents will be informed of and offered the influenza and pneumococcal vaccinations upon admission and annually. If the resident is unsure of dates of vaccinations, nursing will obtain this information. Consent will be obtained on the Adult Vaccine Administration Record and bottom part of the form will be completed once the vaccination has been administered and placed in resident's medical record.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the kitchen floor, 3 compartment sink, the oven, stove top, the common / activity area refrigerator and microwave in a clean and sanitary manner. This had the potential to affect all 26 residents residing in the facility. Findings include:	F 371	F371 FOOD PROCURE, STORE/PREPARE/SERVE SANITARY Kitchen will be cleaned by Administrator and Dietary Staff and new cleaning schedule established. Administrator will meet with Dietary Staff to discuss and establish cleaning schedules and processes, staff duties and policies and procedures. Administrator or designee will perform random audits 3x weekly for 1 month and 1x weekly for 2 months with reports to QA committee regarding findings and follow up. Completion date: 8/28/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 371	Continued From page 26 During the initial kitchen tour on 7/15/13, at 7:10 p.m. with cook-A the entire kitchen floor was observed to be dirty and soiled. There was build up of dirt observed in the corners with dark spots in front of the oven and stoves. There was a large build up of dust observed behind the stoves and there was a plastic bag, piece of paper and dried up food item on the floor, next to the wall behind the stove. The food storage room floor was observed dusty and had dark marks on it. The stove and ovens was observed to have a build up of grease and dirt. The three compartment sink was observed not functioning and the motor had large amount of rust and dirt on it. Cook-A verified the findings and stated they used to have a cleaning schedule but with only a total of three employees they do not have time to get the cleaning competed. The cook stated they do the best they can. On 7/18/13, at 2:03 p.m. the kitchen floor was again observed to be dirty with pieces of debris behind the stove and also cob webs between the back of the stove and the wall. The three compartment sink was not functional and cook-B stated the facility did not have a maintenance man to repair it so they have to wait for a maintenance person from corporate to come fix it and that it had been broken for almost three months. Cook-B stated the sink used to be used for all the big items and now they have to put everything in the dishwasher which took more time. There was a cart observed stacked with empty boxes in the doorway between the store room and the kitchen, water on the floor in front of a freezer. Cook-B verified the kitchen was dirty but stated there was no time to clean as the facility had only 1 cook per shift and they have no	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 371	Continued From page 27 dietary aids or anyone else to help in the kitchen. On 7/18/13, at 2:08 p.m. during the environmental tour of the activity / common area with social service designee (SSD)-A the microwave was observed dirty with food debris inside of it, the refrigerator had noticeable spills and the freezer compartment had excessive frost build up. SSD-A confirmed the findings and stated dietary staff were responsible for cleaning the items. However, SSD-A stated the facility did not have a cleaning schedule for the activity room microwave or refrigerator and was unsure when the last time they were cleaned. On 7/18/13, at 2:30 p.m. the administrator stated she was currently acting as the dietary manger and they are trying to fill that position. The administrator stated the dietary manager was the one who should have made out the cleaning schedule and monitored to make sure the kitchen was clean. The administrator verified the floor was dirty, stoves were greasy, the kitchen was congested, the three compartment sink was broken, and there was water on the floor. On 7/19/13, at 9:20 a.m. Cook-C stated she was the only one in the kitchen during the day to prepare and clean up two meals daily so there was not time to complete all the cleaning. Cook-C stated the cleaning of the kitchen was left for last so it did not get done. Cook-C added, they do the best they can in the time allowed. The undated dietary policy noted it was the food service worker and cook's responsibility to ensure the surfaces of equipment be thoroughly cleans as often as necessary to keep the equipment free	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 371	Continued From page 28 of accumulation of dust, dirt, food particles, and other debris.	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide dental services for 1 of 1 resident (R45) resident reviewed for dental needs. Findings include: R45 had missing teeth and loose lower teeth and the facility failed to assess the need for a potential dental referral. On 7/16/13, at 9:38 a.m. R 45 stated he had an upper plate and only eight lower teeth. R45 stated those teeth are never brushed because they are loose and could fall out. R45 denied pain or any problems eating or chewing.	F 411	F411 ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS R45 was visited with regarding dental exam on 6/26/13 and he declined services; on 7/18/13 R45 stated "maybe down the road". Resident said he will let DDS know when he wants an appointment; on 7/24/13 declined services. MDS, care plan, and CAA's updated on 7/24/13. New admissions will be asked when they had their last exam. Will ask if have any dental issues and if would like assistance in making an appointment. Will document last exam on the "waiting list application" form on admission. Also will be asked quarterly at care plan meetings and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 411	Continued From page 29 R45's diagnosis included a stroke with weakness. The admission Minimum Data Set (MDS) dated 6/21/13, indicated R45 was cognitively intact and required extensive assistance of staff for bathing, dressing and grooming. The MDS also identified R45 as having no dental problems. The Admit Comprehensive Nursing Assessment dated 6/17/13, indicated R45's eyes, ears, nose,mouth, and throat was all clear-no redness or lesions noted. The assessment did not identify any missing or loose teeth. On 7/18/13, at 1:50 p.m. the director of nursing stated she completed the admission MDS. The DON verified the MDS assessment did not identify the missing teeth therefor, dental problems was not triggered and there was no dental referral or interventions related to possible dental needs. The DON stated she had not looked into R45's mouth but reviewed the admit comprehensive nursing assessment to gather her data when she completed the MDS.	F 411	All appropriate staff will be educated on reporting dental services needs. Audits will be done on new admissions and all residents quarterly to address dental needs. Will report to QA for further recommendations. Audits and monitoring will be completed by SSD and/or designee. Completion date: 8/28/13	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 441	Continued From page 30 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain a comprehensive infection control surveillance program. In addition, the facility failed to ensure community razors were adequately disinfected between each resident use. This had the potential to affect all 26 residents. Findings include: On 7/17/13, at 2:18 p.m. the director of nursing (DON) confirmed she coordinated the infection	F 441	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS Infection control surveillance report for Jan, Feb, and March 2013 were reviewed and updated for correlation regarding infections. Infection control reports for April, May, and June were compiled and noted for correlation regarding infections. Both quarters showed no correlation between res/staff infections. Quarterly QA staff meeting was completed and above information was reviewed verbally also and recorded in QA minutes. Information regarding surveillance/correlation will be documented and brought to quarterly QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 441	Continued From page 31 control program. The DON indicated she had conducted random surveillance observations on staff, however was unable to provide any results, analysis or plans for improvement from this surveillance activity. On 7/18/13, at 9:44 a.m. the DON was unable to provide adequate documentation to demonstrate the process of monitoring, tracking and trending staff illnesses in correlation with resident infections in an effort to track potential cross contamination and prevent unnecessary outbreaks. On 7/18/13, at 1:06 p.m. DON confirmed the information she provided on the facility's Organism Nosocomial Infection Report for January, February and March 2013, did not coincide with the January, February, and March 2013, Monthly Nosocomial Infection Report she had provided. She confirmed there were several discrepancies within these two reports. The DON was unable to provide the most recent quarter of data (April, May, June). On 7/18/13, at 2:50 p.m. the medical director confirmed he regularly attended the facility's Quality Assurance and Assessment (QAA) committee and the DON provided the committee with the number of infections like urinary tract infections (UTI's) or pressure ulcer infections. He did not recall having any discussion regarding cross contamination concerns, such as correlation of resident infections to staff infections or surveillance results. The facility's Infection Control policy dated 2/1991, outlined the infection control coordinator's responsibilities to be reporting to the QAA	F 441	Updated razor policy to EPA standards for cleaning community razors. Will have each resident purchase own electric razor for use. All appropriate staff will be educated on infection control surveillance and appropriate razor cleaning. Audits of surveillance will be done monthly and reported quarterly to QA team. Audits of razor cleaning will be done weekly x4, then bi-monthly x2, and then report to QA for further recommendations. Audits will be completed by DON and/or designee. Completion date: 8/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 441	Continued From page 32 committee infection control surveillance, interventions, and action results periodically. On 7/16/13, at 8:35 a.m. nursing assistant (NA)-C confirmed the facility had community razors in the tub rooms which they utilized to shave residents after their bath. NA-C stated the razors were cleaned with alcohol wipes after each use. On 7/28/13, at 8:27 a.m. NA-B demonstrated the razor cleaning process. She removed the top of the razor and shook a large amount of hair shavings from the razor into the sink. NA-B confirmed that the razor had not been cleaned after the last use. She stated she would then remove the heads of the razor and use the small brush to clean the heads. She then retrieved an alcohol prep wipe and stated she would wipe off the razor with the alcohol wipe. The facility's Razor Policy dated 10/1994, directed staff to disinfect the electric shaver heads with alcohol after each use. The Environmental Protection Agency (EPA) indicated the use of alcohol wipes was not effective in killing blood born pathogens such as hepatitis and HIV. On 7/18/13, at 9:42 a.m. DON confirmed the Razor Policy dated 10/1994, is the facility's current policy and practice for cleaning razors.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 465	Continued From page 33 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the common area carpet, and 1 of 2 tub rooms (119B) in a clean and sanitary manner. In addition, the facility failed to provide housekeeping services necessary to maintain resident rooms in a clean and sanitary manner free from offensive odor and fecal debris for 5 of 26 resident bathrooms (107,111,116, 126, 132) reviewed. This had the potential to affect all 26 residents residing in the facility. Findings include: During the facility initial tour on 7/15/13 at 6:20 p.m., the Sunshine unit tub room (119B) toilet seat was observed to have dried feces smeared on it. Additionally, on 7/16/13, at 8:47 a.m. the same tub room toilet seat was observed to have smeared, dried feces on it. During the environmental tour on 7/18/13, at 8:15 a.m. with the director of nursing (DON) the following was observed: Sunshine unit: Room 107: bathroom had a urine odor. Room 111: feces was observed on the toilet seat, rim of the toilet bowl and also on the floor next to the toilet. Room 116: bathroom had a urine odor. Tub room 119B toilet seat was observed to have smeared, dried feces on it.	F 465	F465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT All bathrooms have been cleaned by housekeeping including vents in each bathroom and tub room on August 8 - 9. Carpets were spot cleaned and fully shampooed by Administrator on August 8-9. New policies and procedures relating to housekeeping in resident rooms and bathrooms to be performed by Housekeeping staff and Nursing Assistants will be implemented. New policies and procedures for cleaning carpets, common areas and tub rooms will be implemented and presented to all appropriate staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 465	Continued From page 34 Paradise Unit: Room 126: dried feces was observed smeared on the toilet seat. Room 132: bathroom had a urine odor. Common area: the carpet was observed to have multiple stains which varied in size During the environmental tour the DON verified the findings and stated the resident rooms/bathrooms were cleaned once a week and should also be cleaned in between as needed. The DON stated the rooms/ bathrooms/carpet/toilets should have been cleaned. Additionally, the DON stated the facility did not have a policy and procedure related to resident room/bathroom/carpet cleaning requirements. The DON also stated the administrator was in charge of the housekeeping services. On 7/18/13, at 9:46 a.m. the environmental service worker (ESW) stated the urine smell was an ongoing problem that had improved. The ESW also stated the staff were directed to clean the bathrooms weekly and spray a deodorizer as needed to eliminate the odors. The ESW also stated she had previously talked to the administrator about the concern with resident room odors. At 1:22 p.m. during a telephone interview the	F 465	Audits of resident rooms and bathrooms will be completed randomly 3x weekly for 2 months and randomly 1x weekly for 2 months with reports to QA for further recommendations and follow up. Administrator or designee will be responsible for audit completion and follow up. Completion date: 8/28/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	123 BAKEN STREET THIEF RIVER FALLS, MN 56701

(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 465	Continued From page 35 administrator / head of housekeeping verified the carpet stains and stated the carpet should be cleaned/shampooed by the environmental service worker (ESW) every two weeks and as needed. The administrator also stated the shower toilet should have been cleaned. Additionally, the administrator stated the facility did not have a policy and procedure related to carpet / tub room cleaning. At 1:33 p.m. the ESW verified the stained carpet and stated the last time she had shampooed the carpet was in the beginning of the year.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Oakland Park Nursing Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	RECEIVED SEP 16 2013 DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL Poc ok TL 9/6/13 Last Date 9/13/13	

DC: 08.28.2013

EXIT: 07.19.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Malone	Administrator	8/20/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

(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
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Oakland Park Nursing Home is a 1-story building without a basement and was constructed in 1975. It was determined to be of Type II(111) construction. The facility is divided into 3 smoke zones by 30 minute fire barriers and is separated from the north apartment wing by a 2-hour fire barrier . The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system with smoke detection at the smoke barriers for door release, in all sleeping rooms and in common areas that are on the fire alarm system installed in accordance with NFPA 72 "The National Fire Code" (1999 edition). The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire alarm system in	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

(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
K 000	Continued From page 2 accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 40 beds and had a census of 25 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Observations and testing of at least 30 corridor doors revealed that 4 do not comply with NFPA	K 018	**K018** The doors noted during survey to not positively latch will be repaired to assure compliance. Administrator and/or Maintenance personnel will do monthly audits to assure corridor doors positively latch. Completion Date: September 13, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

(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
K 018	Continued From page 3 101 "The Life Safety Code" 2000 Edition Section 19.3.6.1. If rooms do not have corridor doors that latch, a fire could spread beyond the room of origin and would negatively impact all the residents, visitors and staff. Findings include: During the facility tour on July 17, 2013, between 10:15 am and 12:15 pm, observations and testing of corridor doors, by surveyor 03006, revealed that the following did not positively latch: 1) Soiled utility room 119D 2) Soiled utility room 136D 3) Linen room 136H, and 4) Resident room 109 The Administrator verified these findings during the facility tour and during the exit conference.	K 018	**K056** The missing ceiling tile was replaced on July 19, 2013 by Maintenance personnel. A sprinkler is scheduled to be installed in the walk-in freezer the week of August 26, 2013. Maintenance personnel under the supervision of the Administrator will assure all ceiling tiles are in place as required. The Administrator will assure the sprinkler head is installed. Completion Date: September 13, 2013	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by:	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK COMMUNITIES	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

(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
K 056	Continued From page 4 Observations indicated that the automatic sprinkler system is not installed in accordance with NFPA 13 Standard for The Installation of Sprinkler Systems, 1999 edition. This deficient practice would allow a fire to extend above the suspended ceiling into a space that is not sprinkler protected, which will negatively impact all the residents, visitors and staff in these areas. Findings include: During the facility tour on July 17, 2013, between 10:15 am and 12:15 pm, observations by surveyor 03006, revealed that: 1) A ceiling tile was damaged and removed in the PT/ OT room, and 2) The walk-in freezer in the kitchen is not protected by the automatic sprinkler system. The Administrator verified these findings during the facility tour and during the exit conference.	K 056		