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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QFZE

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 08/22/2014 (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:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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): On August 22, 2014 a Post Certification Revisit (PCR) was completed at this facilty and verified correction of health and life safety code deficiencies pursuant to the extended survey completed on June 27, 2014, effective August 6, 2014, refer to the CMS 2567b forms for the results of this visit. Effective August 6, 2014, the facility is certified for 40 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Debra Vincent, HFE NEII — 08/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 10/13/2014~ (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 10/23/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5592

August 27, 2014

Mr. Tyler Ahlf, Administrator
Oakland Park Communities
123 Baken Street
Thief River Falls, MN 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 August 6, 2014 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 27, 2014

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

RE: Project Number S5592023

Dear Mr. Ahlf:

On July 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on June 27, 2014. 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.

On August 22, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 8, 2014 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 an extended survey, completed on June 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 6, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 27, 2014, effective August 6, 2014 and therefore remedies outlined in our letter to you dated July 15, 2014, will not be imposed.

However, as we notified you in our letter of July 15, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 27, 2014.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

5592r14

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245592	A. Building B. Wing	8/22/2014

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 **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0161** Reg. # **483.10(c)(7)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/06/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **08/06/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	08/27/2014	27200	08/22/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245592	A. Building B. Wing	8/22/2014

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 **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0387** Reg. # **483.40(c)(1)-(2)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0518** Reg. # **483.75(m)(2)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **08/06/2014**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	08/27/2014	27200	08/22/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/27/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

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	8/8/2014

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

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0046	Correction Completed **06/26/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 08/27/2014	**Signature of Surveyor:** 27200	**Date:** 08/22/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/25/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245592	A. Building B. Wing	8/22/2014

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).

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ID Prefix **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0161** Reg. # **483.10(c)(7)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/06/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **08/06/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **08/06/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	08/27/2014	32981	08/22/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245592	A. Building B. Wing	8/22/2014

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 **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **08/06/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **08/06/2014**
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ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **08/06/2014**				

Reviewed By _____ **State Agency**	**Reviewed By** LB/mm	**Date:** 08/27/2014	**Signature of Surveyor:** 32981	**Date:** 08/22/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/27/2014	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00449	A. Building B. Wing	8/22/2014

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20280** Reg. # **MN Rule 4658.0100 Subp. 1** LSC	Correction Completed **08/06/2014**	ID Prefix **20302** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **08/06/2014**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **08/06/2014**
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **08/06/2014**	ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp. 1** LSC	Correction Completed **08/06/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **08/06/2014**
ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp. 2.B** LSC	Correction Completed **08/06/2014**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **08/06/2014**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **08/06/2014**
ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp. 6 B** LSC	Correction Completed **08/06/2014**	ID Prefix **20930** Reg. # **MN Rule 4658.0525 Subp. 7 B.** LSC	Correction Completed **08/06/2014**	ID Prefix **21290** Reg. # **MN Rule 4658.0710 Subp. 3 A** LSC	Correction Completed **08/06/2014**
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 4** LSC	Correction Completed **08/06/2014**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	Correction Completed **08/06/2014**	ID Prefix **21910** Reg. # **MN St. Statute 144.651 Subd. 2** LSC	Correction Completed **08/06/2014**

Reviewed By _____ **State Agency**	**Reviewed By** LB/mm	**Date:** 08/27/2014	**Signature of Surveyor:** 32981	**Date:** 08/22/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00449	A. Building B. Wing	8/22/2014

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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
ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Subd. 4** LSC	**08/06/2014**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	**08/06/2014**		

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	08/27/2014	32981	08/22/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/27/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: D4TP

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 **06/27/2014** (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):

17. SURVEYOR SIGNATURE — Date :
Debra Vincent, HFE NEII — 07/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/22/2014 (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 08/22/2014 Co.

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

Electronically delivered
July 15, 2014

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

RE: Project Number S5592023

Dear Mr. Ahlf:

On June 27, 2014, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

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

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

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

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;

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate

jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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 Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (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 August 6, 2014, 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 August 6, 2014 the following remedy will be imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Oakland Park Communities is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective June 27, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 27, 2014 (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 December 27, 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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5592s14.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 _____	06/27/2014

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on 6/26/14 and 6/27/14.	F 000		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest	F 159		8/6/14

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

Electronically Signed | 07/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 159	Continued From page 1 bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents' personal funds in excess of $50.00 were maintained in an interest bearing account for 17 of 23 residents (R3, R19, R23, R11, R2, R5, R8, R21, R28, R16, R10, R20, R7, R9, R22, R1, R33) whose personal funds were in excess of $50.00 and were managed by the facility.	F 159	All residents including R3,R19,R23,R11,R2,R5,R8,R21,R28,R16,R10,R20,R7,R9,R22,R1,R33 have their funds in an interest bearing account as applicable. 3. Policy and procedure reviewed and updated. Administrator or Designee has established one interest bearing account for all resident funds and	

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F 159	Continued From page 2 Findings include: On 6/26/14, at 10:55 a.m. resident personal funds accounts were reviewed with the business office manager (BOM). The BOM stated the facility had a separate trust account for the residents' personal funds monies but she did not know if this account was interest bearing. On 6/26/14, at 1:27 p.m. the administrator stated he checked with the bank and confirmed the facility currently had the resident funds in a non-interest bearing account. At 1:31 p.m. the BOM stated the facility currently did not manage personal funds for any residents receiving Medicare benefits and verified the following residents had an account balance greater than $50.00 since the previous survey. -R3's Trust Account Statement was reviewed from 3/7/14, through 6/17/14, and had account balances of $147.65 on 3/7/14, $137.65 on 4/4/14, $157.01 on 5/5/14, and $223.62 on 6/6/14. The account had fifteen debits and ten credits. No interest was posted to the account. -R19's Trust Account Statement was reviewed from 12/31/13, through 6/24/14, and had account balances of $74.00 on 12/31/13, $53.00 on 2/13/14, $76.00 on 3/21/14, $80.75 on 5/12/14, and $198.75 on 6/24/14. The account had twenty-five debits and 6 credits listed. No interest was posted to the account. -R23's Trust Account Statement was reviewed from 7/24/13, through 6/24/14, and had account balances of $123.64 on 8/1/13, $155.64 on	F 159	will be audited weekly for 4 weeks and monthly thereafter. Findings will be reported to QAA for recommendations & review.	

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F 159	Continued From page 3 9/3/13, $159.64 on 9/30/13, $111.64 on 10/29/13, $95.64 on 11/19/13, $109.64 on 12/10/13, $135.64 on 1/1/14, $84.64 on 2/4/14, $102.64 on 2/28/14, $108.64 on 3/28/14, $56.14 on 4/9/14, $50.64 on 5/1/14, and $79.64 on 6/3/14. The account had forty-three debits and twelve credits. No interest was posted to the account. -R11's Trust Account Statement was reviewed from 3/24/14, through 6/24/14, and had account balances of $100.00 on 3/24/14, $75.44 on 4/24/14, $135.44 on 5/20/14, and $54.44 on 6/24/14. The account had nine debits and three credits. No interest was posted to the account. -R2's Trust Account Statement was reviewed from 7/24/13, through 6/24/14, and had account balances of $65.00 on 7/29/13, $70.00 on 8/22/13, $75.00 on 10/22/13, $67.00 on 12/31/13, $78.00 on 1/28/14, $106.00 on 3/24/14, $78.00 on 4/9/14, $71.00 on 5/5/14, and $79.00 on 6/17/14. The account had forty-one debits and ten credits listed. No interest was posted to the account. -R5's Trust Account Statement was reviewed from 2/21/14, through 6/25/14, and had account balances of $50.00 on 2/21/14, $55.00 on 4/17/14, $60.00 on 4/23/14, and $106.00 on 6/13/14. The account had sixteen debits and six credits listed. No interest was posted to the account. -R8's Trust Account Statement was reviewed from 8/6/13, through 6/24/14, and had account balances of $68.25 on 9/6/13, $73.25 on 11/20/13, $100.25 on 12/16/13, $55.67 on 4/17/14, $58.67 on 5/8/14 and $59.67 on 6/16/14. The account had thirty-five debits and ten credits	F 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 159	Continued From page 4	F 159		

listed. No interest was posted to the account.

-R21's Trust Account Statement was reviewed from 7/24/13, through 6/24/14, and had account balances of $50.25 on 7/31/13, $54.75 on 10/11/13, $55.75 on 12/17/13, $89.75 on 2/25/14, $51.75 on 3/18/14, $50.00 on 4/8/14, and $50.00 on 5/6/14. The account had forty-five debits and eleven credits. No interest was posted to the account.

-R28's Trust Account Statement was reviewed from 2/4/14, through 5/9/14, and had account balances of $84.00 on 2/6/14, $50.22 on 3/3/14, $70.22 on 3/17/14, $70.22 on 4/3/14, and $50.22 on 50.22. The account had ten debits and five credits. No interest was posted to the account.

-R16's Trust Account Statement was reviewed from 3/3/14, through 6/25/14, and had account balances of $51.50 on 4/4/14, and $74.60 on 6/3/14. The account had seventeen debits and eight credits listed. No interest was posted to the account.

-R10's Trust Account Statement was reviewed from 3/25/14, through 6/17/14, and had account balances of $61.00 on 4/25/14, $73.50 on 5/23/14 and $61.50 on 6/23/14. The account had two debits and four credits listed. No interest was posted to the account.

-R20's Trust Account Statement was reviewed from 9/3/13, through 5/27/14, had account balances of $65.00 on 9/3/13, and $55.00 on 11/4/13. The account had six debits and two credits. No interest was posted to the account.

-R7's Trust Account Statement was reviewed

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F 159	Continued From page 5 from 7/29/13, through 2/10/14, and had an account balance of $60.00 on 1/27/14. The account had thirteen debits and five credits. No interest was posted to the account. -R9's Trust Account Statement was reviewed from 5/23/14, through 5/27, and had an account balance of $60.00 on 5/23/14. The account had one debit and one credit listed and no interest was posted to the account. --R22's Trust Account Statement was reviewed from 8/20/13, through 6/24/14, and had account balances of $57.00 on 9/27/13, $59.00 on 11/4/13, $57.00 on 12/13/13, $59.00 on 2/4/14, $57.00 on 3/4/14, $53.00 on 4/9/14 and $53.00 on 4/30/14. The account had forty-one debits and nine credits. No interest was posted to the account. -R1's Trust Account Statement was reviewed from 7/24/13, through 5/27/14, and had an account balance of $58.00 on 12/13/13, and $53.11 on 1/20/14. The account had six debits and two credits listed. No interest was posted to the account. -R33's Trust Account Statement was reviewed from 5/5/14, through 6/24/14, and had an account balance of $52.25 on 6/9/14. The account had seven debits and four credits. No interest was posted to the account. The Resident Trust Fund Policy dated 3/2007, indicated "Personal funds of residents not in excess of $50.00 are deposited with the Business Office of Oakland Park Communities as a separate non-interest bearing account with individual accountability maintained by the	F 159		

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	245592	A. BUILDING _____ B. WING _____	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 159	Continued From page 6 Home."	F 159		
F 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure surety bond coverage equal to the actual resident fund account balances for 17 of 17 residents (R9, R10, R5, R1, R19, R16, R2, R21, R33, R3, R20, R28, R7, R8, R23, R22, R11) reviewed who had personal fund accounts managed by the facility. Findings include: The facility's Resident Trust Fund Policy dated 3/2007, indicated, "The resident Trust Funds are protected by a surety bond." On 6/27/14, at 11:57 a.m. the administrator confirmed the facility did not have a surety bond equal to at least the current total amount of resident funds.	F 161	1.All residents including R9,R10,R5,R1,R19,R16,R2,R21,R33,R3, R20,R28,R7,R8,R23,R22,R11 that have their personal funds deposited with facility are protected by a surety bond. 3. Policy and procedure reviewed and updated. Administrator or Designee has ensured Resident Trust Fund Account is protected by a surety bond. Administrator or Designee will audit weekly for 4 weeks and monthly thereafter to ensure Resident Trust Fund Account does not exceed Surety Bond amount. Findings will be reported to QAA for recommendation & review.	8/6/14
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		8/6/14

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F 225	Continued From page 7 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential abuse and neglect to the state agency (SA) and to thoroughly investigate the incidents of possible abuse and neglect of care 1 of 1	F 225	1.Instances regarding R9,R29,R7,R13,R21,R6 have been reported to SA per issuance of this deficiency. Staff including, NA-A, NA-J, NA-D, DA- A, have completed	

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F 225	Continued From page 8 resident, (R9) who had allegations of verbal abuse by a staff member, for 2 of 2 resident's (R29, R7), who were involved in a resident to resident altercation, for 2 of 2 residents (R29, R13) who had allegations of misappropriation of funds, and for 2 of 2 resident's (R21, R6), who sustained bruises of unknown origin. In addition, the facility failed to ensure 4 of 5 newly employed nursing assistants (NA-A, NA-J, NA-D), and a dietary aide (DA- A), had a background study completed prior to providing direct resident care. This had the potential to affect all 26 resident's currently residing in the facility. Findings include: R9 reported to have been abused by a nursing assistant which was not thoroughly investigated. R9's admission Minimum Data Set (MDS) dated 3/31/14, identified R9 had severe cognitive impairment, was totally dependent upon staff, and required two person physical assistance with bed mobility, transferring, and toileting. The MDS also indicated R9 required one staff assistance with dressing and personal hygiene. On 6/26/14, at 12:00 p.m. licensed practical nurse (LPN)-D stated nursing assistant (NA)-F had reported to her an incident involving NA-K and R9. NA-F stated she was working with NA-K providing cares for R9. NA-F stated when R9 was resistive with cares, NA-K told the resident to, "lick my balls." LPN-D stated she immediately reported the incident to the administrator. LPN-D stated she was later upset to see NA-K still working with residents. She stated when she asked the administrator about the incident she had reported, she was told "They [facility] needed	F 225	background studies. 2. All instances where a resident is involved with the potential for neglect or abuse will be reported to the SA immediately. Additionally, all current and prospective staff will have a current background study completed and on file. 3. Resident Abuse Policy reviewed and updated. All staff educated on policy changes. All instances are reported immediately to the Administrator. Administrator or Designee will investigate any and all instances per updated Resident Abuse Policy. 4. Administrator or Designee will audit report sheets daily for one month to ensure all suspected events have been reported and to continue thereafter until 100% compliance is assured. Business Office Manager has reviewed all employee records to ensure completed background studies are on file. All new employees will have a completed background study prior to assuming their job duties in resident care area. Business Office Manager maintains on going personnel jacket checklist. Findings will be reported to QAA for recommendation & review.	

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to investigate the incident."

On 6/26/14, at 2:19 p.m. the administrator stated the incident regarding NA-K and R9 was reported to him by LPN-D. The Administrator stated he and director of nursing (DON) met with NA-K, who denied making the statement. Administrator indicated this was discussed with NA-K prior to NA-K returning to work. The Administrator confirmed he did not fill out an incident report or a vulnerable adult report nor did he report the incident to the SA but stated he had documented the conversation in NA-K's personnel record.

Review of NA-K's personnel record revealed a note written on a paper Progress Note by the DON which indicated, "5/28/14, received report per administrator that another employee had reported that [NA-K] made an inappropriate comment to [R9]. This writer, administrator, and [NA-K] met today regarding this. Informed him that we received a report that he had told [R9] to "lick my scrotum." [NA-K] adamantly denied saying that and he would never say that. Counseled him that inappropriate comments would not be tolerated and would be unacceptable and result in further discipline. He did verbalize understanding of this also." There was no further investigation of this incident.

On 6/26/14, at 3:25 p.m. NA-F stated neither the DON or the administrator interviewed her about the incident with NA-K making an inappropriate statement to R9. NA-F stated NA-K continued to work at the facility until he resigned about a week later and continued to be rude to resident's and, "Everyone knew it."

On 6/26/14, at 3:30 p.m. the Administrator

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confirmed he did not interview NA-F regarding the incident and the documentation in NA-K's personnel record was the extent of the investigation. The Administrator also confirmed the incident was not reported to the SA.

R7 and R27 were observed to abuse each other during an altercation. The incident was not reported timely to the administrator or SA.

A facility vulnerable adult (VA) report dated 6/6/14, at 7:00 p.m. indicated R7 wheeled into R27's room. Licensed practical nurse (LPN)-D heard the resident's yelling at each other. When she went to investigate the concern, she found R7 and R27 striking at each other. Review of R7 and R27's clinical record indicated the Administrator was notified of the incident on 6/7/14, at 8:50 am. Review of the facility VA report revealed the incident was reported to the SA on 6/7/14, at 11:35 A.M., (16 hours and 30 minutes later)

R29 reported missing money without timely reporting to the administrator and SA.

A VA report dated 5/26/14,(no time identified) indicated R29 had reported he was missing an undisclosed amount of money which he noticed was missing when he went to bed. The documentation did not indicate when the administrator was notified of the concern and indicated the SA was notified on 5/27/14, at 3:30 p.m., (greater than 17 hours later).

A VA report dated 3/16/14, (no time identified) indicated R29 had reported he was missing $30-$40. The report did not indicate when the

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administrator was notified of the incident. The SA was notified on 3/17/14, at 2:20 p.m., (greater than 14 hours later).

R13 reported missing money without timely reporting to the administrator and SA.

A VA report dated 4/22/14,(no time identified) indicated R13 reported to the staff she was missing $40.00. The report did not identify when the administrator was notified. The SA was notified on 4/23/14, at 2:30 p.m., (greater than 14 hours later).

On 6/24/14, at 2:30 p.m. the social service designee (SSD) stated she generally was informed when there was a VA concern in the facility. She stated if the concern occurred on the evening shift, she would be notified in the morning and complete any follow up investigation's to the state agency the next morning. She stated the administrator and the DON may start an initial investigation, but she completed the investigation and would report to the SA. The SSD stated all reports which required notification of the SA would be completed within 24 hours.

On 6/24/14, at 2:45 p.m. LPN-C stated any time a concern of abuse was identified, the administrator and the DON would be notified immediately of the concern and they would complete an investigation. LPN-C stated she had not received training on how to report concerns to the SA.

On 6/24/14, at 2:50 p.m. LPN-E stated she had been working at the facility for approximately one month and would report any concerns to the DON

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F 225	Continued From page 12 or the Administrator. LPN-E stated she had not received training on how to report concerns to the state agency. On 6/24/14, at 2:55 p.m. the Administrator stated any time a concern related to VA was brought forward, he was notified immediately and the SA was also notified immediately. The Administrator stated immediately, according to the facility policy, allowed for a 24 hour window to ensure it was a true abuse concern. On 6/24/14, at 2:56 p.m. the DON verified the facility staff were instructed to determine if the allegation met the definition of abuse, and had 24 hours to make the determination if it needed to be reported to the SA. On 6/24/14, at 3:00 p.m. the Administrator stated he was unaware the facility was required to report potential allegations of abuse immediately to himself and the SA and that he did not have a 24 hour window of time to determine if the allegation was abusive or not. On 6/25/14, at 6:32 a.m. LPN-B, who worked the night shift, stated if two resident's were in a physical altercation, she would attempt to calm and separate them, document the behavior and notify family if the residents were hurt. LPN-B also stated if the residents hurt each other, she would notify the DON and the Administrator. LPN-B added, if they did not hurt each other, she would not notify the Administrator nor DON. Additionally, LPN-B stated she was not aware nor had been instructed that physical abuse between residents that did not result in injury was a reportable incident.	F 225		

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F 225	Continued From page 13 On 6/25/14, at 12:00 p.m. the DON stated bruises of unknown origin were documented on a specific form which were then reviewed with the DON. R21 sustained an injury of unknown origin without timely notification of the Administrator and the SA. An Injury of Unknown Origin report dated 3/17/13, at 10:00 a.m. indicated R21 was noted to have a large bruise on the left side of the belly and that she was unable to describe where it came from. Review of the documentation indicated the Administrator was notified on 3/18/14, after the staff had completed an investigation and determined the bruise was a side effect of medication received while she was in the hospital. The SA was not notified of the injury of unknown origin. R6 sustained an injury of unknown origin without timely notification of the Administrator and the SA. An Injury of Unknown Origin report dated 3/4/14, at 8:10 p.m. indicated staff had identified a 4 inch by 1/2 inch purple bruise on R6's leg. The resident was unable to recall where the bruise came from. The administrator was notified of the bruise on 3/5/14. The DON completed an investigation and felt the bruise was sustained from a side rail attachment. The injury was not reported to the SA. On 6/25/14, at 2:30 p.m. LPN-A stated if a resident was found with an injury of unknown origin, she would ask the resident what happened. If the resident was unable to identify the origin of the injury, she would start an investigation to determine the cause of the bruise. LPN-A stated she would document the concern in	F 225		

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the nurses notes, but would not report the concern to the SA.

On 6/25/14, at 2:35 p.m. LPN-D stated if she noticed an injury of unknown source, she would notify the DON and chart the concern in the nurses notes. LPN-D stated she would not report injuries of unknown source to the SA.

On 6/25/14, at 2:40 p.m. the DON stated she investigated the injures of unknown source and reported them as necessary. She stated she preferred to investigate the bruise to attempt to determine the origin and report only if the origin could not be identified. When asked if she completed the investigations prior to notifying the SA the DON stated, "Sometimes."

Background Studies:

Review of employee personnel records identified the following information:

NA-J was hired on 9/2/2011. A hand written note completed by the DON dated 9/22/11, indicated the facility had received a background study from the State of Minnesota and NA-J was not to be working with vulnerable individuals. The personnel record lacked further documentation related to NA-J's background study.

NA-A was hired on 4/25/14. The personal record did not contain a background study.

NA-D was hired on 12/12/13. A background study was completed on 11/21/13, which indicated the facility may or may not wish to allow NA-D to provide care while the study was being

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F 225	Continued From page 15 completed. The personal record did not include the final determination of the background study. DA-A was hired at the facility on 5/13/14. The personal record did not contain a background study. On 6/26/14, at 2:00 p.m. the Administrator stated the background screenings were completed by the former Administrator. He stated he was unable to gain access to the website which would allow him to determine if the staff members had passed their background screenings. He stated he had not been notified the above staff members were not able to provide cares. In addition, he stated NA-A and NA-D had worked at another facility owned by the same cooperation, however, stated when hired at this facility a new background study was required. The Administrator stated he could not obtain the former facility background studies. On 6/26/14, at 2:10 p.m. the DON stated she could recall the situation related to NA-J's background information and for a time she was unable to provide cares to the residents. She stated NA-J returned to the facility after the concern was cleared. The DON verified NA-J's personal record did not contain documentation related to when she was cleared for employment. On 6/26/14, at 3:30 p.m. the Administrator provided information which indicated DA-A had passed a background study on 7/2/1996, and NA-A was able to provide care while the background study dated 11/20/12, (which was at former facility) was being completed. The Administrator stated he had requested new background studies on all four employees to	F 225		

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F 225	Continued From page 16 ensure compliance with the regulation. The Abuse Prevention Plan dated 3/2012, indicated the facility would, in good faith, comply with the Minnesota Statue 626.557 "Reporting of Maltreatment of Vulnerable Adults." The policy directed the staff to report to the Minnesota Department of Health (MDH) and the Common Entry Point (CEP) immediately but no longer than 24 hours hours of the allegation as per federal regulation. The policy defined abuse as the willful infection of injury, unreasonable confinement, intimidation, punishment with resulting physical harm, pain or mental anguish. It defined verbal abuse as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their family regardless of their age, ability to comprehend or disability. Injuries of unknown source were identified as any injury which was not observed by any person or the source of the injury could not be explained by the resident and the injuries was suspicious because of the extent of the injury to the location. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful , temporary or permanent use of a resident's belonging or money without resident concern. The policy directed staff to report incidents of abuse immediately, but no longer than 24 hours after the discovery of the report to the SA. This guidance was incorrect, as the word immediately is defined as "without delay" and does not allow for a 24 hour reporting window. In addition the policy directed the staff to contact the administrator, if unable to reach, they were to contact the director of nursing (DON) or the social services designee. The notification of the	F 225		

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F 225	Continued From page 17 Administrator could be completed by leaving a message for him/her, the DON or the SSD. This is also incorrect guidance as the facility administrator was to be contacted immediately, which is defined as "without delay." In addition, the Abuse Prevention Plan dated 3/2012, directed the facility to complete background studies on all potential new staff members.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop and implement policies and procedures related to the required immediate reporting of possible abuse and/or neglect of care to the Administrator and State agency (SA), and conduct thorough investigations for 1 of 1 resident (R9) who made allegations of verbal abuse by a staff member, for 2 of 2 residents (R27, R7), who were involved in a resident to resident altercation, for 2 of 2 residents (R29, R13) with complaints of misappropriation of funds, and for 2 of 2 residents (R21, R6) who sustained injury of unknown origin. In addition, the facility failed to ensure 3 of 5 newly employed nursing assistants (NA-A, NA-J, NA-D) and one dietary aide (DA- A) had background checks	F 226	1.See F225	8/6/14

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OAKLAND PARK COMMUNITIES	**123 BAKEN STREET THIEF RIVER FALLS, MN 56701**

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F 226	Continued From page 18 completed prior to providing direct resident care as instructed per facility policy. This had the potential to affect all 26 resident's currently residing in the facility. Findings include: The Abuse Prevention Plan dated 3/2012, indicated the facility would, in good faith comply with the Minnesota Statue 626.557, "Reporting of Maltreatment of Vulnerable Adults." The policy directed staff to report to the Minnesota Department of Health (MDH), [state agency], immediately, but no longer than 24 hours, the allegation as per federal regulation. The policy defined abuse as the willful infection of injury, unreasonable confinement, intimidation, punishment with resulting physical harm, and/ or pain or mental anguish. The policy defined verbal abuse as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to a resident or their family, regardless of their age, ability to comprehend, or disability. Injuries of unknown source were identified as any injury which was not observed by any person or the source of the injury could not be explained by the resident and the injuries was suspicious because of the extent of the injury to the location. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful , temporary or permanent use of a resident's belonging or money without resident concern. The policy directed the staff to report incident(s) of abuse immediately, but no longer than 24 hours, after the discovery. This guidance was incorrect, as the word immediately is defined as "without delay" and does not allow for a 24 hour reporting window. In addition, the policy directed	F 226		

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F 226	Continued From page 19 staff to contact the administrator, and if they were unable to reach the administrator, they were to contact the director of nursing (DON), or the social service designee. The notification of the Administrator could be completed by leaving a message for him/her, the DON, or the SSD. This is also incorrect guidance as the facility administrator is to be contacted immediately, which is defined as "without delay." In addition the Abuse Prevention Plan directed the facility to complete background studies on all potential new staff members. R9 was reported to have been abused by a nursing assistant which was not thoroughly investigated. R9's admission Minimum Data Set (MDS) dated 3/31/14, identified R9 had severe cognitive impairment and was totally dependent upon staff and required two staff to assist with bed mobility, transferring and toileting. The MDS also indicated R9 required one staff physical assistance with dressing and personal hygiene. On 6/26/14, at 12:00 p.m. licensed practical nurse (LPN)-D stated nursing assistant (NA)-F had reported an incident to her involving NA-K and R9. NA-F stated she was working with NA-K providing cares to R9. NA-F stated when R9 was resistive with cares, NA-K told the resident to, "Lick my balls." LPN-D stated she immediately reported the incident to Administrator. LPN-D stated she was later upset to see NA-K was still working with residents and when she asked the Administrator about it, she was told, "They [facility] needed to investigate the incident."	F 226		

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On 6/26/14, at 2:19 p.m. the Administrator stated the incident regarding NA-K and R9 was reported to him by LPN-D. The Administrator stated he and the director of nursing (DON) met with NA-K, who denied making the statement to R9. The Administrator stated this had been discussed with NA-K prior to NA-K returning to work. The Administrator confirmed he did not fill out an incident report or a vulnerable adult report nor did he report the incident to the SA but documented the conversation in NA-K's personnel record.

Review of NA-K's personnel record revealed a note written on a paper Progress Note by the DON which read: "5/28/14 Received report per administrator that another employee had reported that [NA-K] made an inappropriate comment to [R9]. This writer, administrator and [NA-K] met today regarding this. Informed him that we received a report that he had told [R9] to 'lick my scrotum'. [NA-K] adamantly denied saying that and he would never say that. Counseled him that inappropriate comments would not be tolerated and would be unacceptable and result in further discipline. He did verbalize understanding of this also."

On 6/26/14, at 3:25 p.m. NA-F stated neither the DON nor Administrator interviewed her about the incident with NA-K making an inappropriate statement to R9. NA-F stated NA-K continued to work at the facility until he resigned about a week later and continued to be rude to residents and "everyone knew it."

On 6/26/14, at 3:30 p.m. the Administrator confirmed he did not interview NA-F regarding the incident and the documentation in NA-K's

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F 226	Continued From page 21 personnel record was the extent of the investigation. R7 and R27 were observed to abuse each other during an altercation. The incident was not reported timely to the Administrator and SA. A vulnerable adult (VA) report dated 6/6/14, at 7:00 p.m. indicated R7 had wheeled into R27's room. LPN-D heard the residents yelling at each other. When she went to investigate the concern, she found R7 and R27 striking out at each other. Review of R7 and R27's clinical record indicated the Administrator was notified of the incident on 6/7/14, at 8:50 am. Review of the VA report revealed the incident was reported to the SA on 6/7/14, at 11:35 A.M. (16 hours and 30 minutes later). R29 reported missing money without timely reporting to the administrator and SA. A VA report dated 5/26/14, (no time identified) indicated R29 had reported he was missing an undisclosed amount of money which he noticed was missing when he went to bed. The documentation did not indicate when the Administrator was notified of the concern and indicated the SA was notified on 5/27/24 at 3:30 p.m. (greater than 17 hours later.) R13 reported missing money without timely reporting to the administrator and SA. A VA report dated 4/22/14, (no time identified) indicated R13 reported to the staff she was missing $40.00. The report did not identify when the Administrator was notified. The SA was	F 226		

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notified on 4/23/14, at 2:30 p.m. (greater than 14 hours later.)

R29 reported missing money without timely reporting to the administrator and SA.

A VA report dated 3/16/14, (no time identified) indicated R29 had reported he was missing $30-$40. The report did not indicate when the Administrator was notified of the incident. The SA was notified on 3/17/14, at 2:20 p.m. (greater than 14 hours later.)

On 6/24/14, at 2:30 p.m. the social service designee (SSD) stated she generally was informed when there was a VA concern in the facility. She stated if the concern occurred on the evening shift, she would be notified in the morning and would complete any follow up investigations and report to the SA the next morning. She stated the Administrator and the DON may start and an initial investigation, but she completed the investigation and reported to the SA. The SSD stated all reports which required notification of the SA would be completed within 24 hours.

On 6/24/14, at 2:45 p.m. LPN-C stated any time a concern of abuse was identified, the Administrator and the DON would be notified immediately of the concern and they would complete an investigation. LPN-C stated she had not received training on how to report concerns to the SA.

On 6/24/14, at 2:50 p.m. LPN-E stated she had been working at the facility for approximately one month and would report any concerns to the director of nursing or the Administrator. LPN-E stated she had not received training on how to

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F 226	Continued From page 23 report concerns to the SA. On 6/24/14, at 2:55 p.m. the Administrator stated any time a concern related to VA was brought forward, he was notified immediately and the SA was also notified immediately. The administrator stated immediately according to the facility policy allowed for a 24 hour window of time to ensure it was a true abuse concern. On 6/24/14, at 2:56 p.m. the DON verified the facility staff were allowed to determine if the allegation met the definition of abuse and they were allowed 24 hours to make that determination. On 6/24/14, at 3:00 p.m. the Administrator stated he was unaware the facility was to report the potential allegations of abuse immediately to himself and the SA and that he did not have a 24 hour window of time to determine if the allegation was abusive or not. On 6/25/14, at 6:32 a.m. LPN-B, who worked the night shift, stated if two residents were in a physical altercation she would attempt to calm and separate them, document the behavior and notify family if the residents were hurt. LPN-B also stated if the residents hurt each other, she would notify the DON and the Administrator. LPN-B added, if they did not hurt each other, she would not notify the DON nor the Administrator. Additionally, LPN-B stated she was not aware nor had been instructed that physical abuse between residents that did not result in injury was a reportable incident. On 6/25/14, at 12:00 p.m. the DON stated bruises of unknown origin were documented on a specific	F 226		

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form. At that time, the bruises of unknown origin were reviewed.

R21 sustained and injury of unknown origin without timely notification of the Administrator and the SA.

An Injury of Unknown Origin report dated 3/17/13, at 10:00 a.m. indicated R21 was noted to have a large abuse on the left side of the belly that she was unable to describe where it came from. Review of the documentation indicated the Administrator was notified on 3/18/14, after the staff had completed an investigation and determined the bruise was a side effect of medication received while she was in the hospital. The SA was not notified of the injury of unknown origin.

R6 sustained and injury of unknown origin without timely notification of the administrator and the SA.

An Injury of Unknown Origin report dated 3/4/14, at 8:10 p.m. indicated staff had identified a 4 inch by 1/2 inch purple bruise on R6's leg. The resident was unable to recall where the bruise came from. The Administrator was notified of the bruise on 3/5/14. The DON completed an investigation and felt the bruise was sustained from a side rail attachment. The injury was not reported to the SA.

On 6/25/14, at 2:30 p.m. LPN-A stated if a resident was found with an injury of unknown origin, she would ask the resident what happened. If the resident was unable to identify the origin of the injury, she would start an investigation to determine the cause of the bruise. LPN-A stated she would document the concern in

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the nurses notes but would not report the concern to the SA.

On 6/25/14, at 2:35 p.m. LPN-D stated if she noticed an injury of unknown source, she would notify the DON and chart the concern in the nurses notes. LPN-D stated she did not report injuries of unknown source to the SA.

On 6/25/14, at 2:40 p.m. the DON stated she investigated the injures of unknown source and reported them as necessary. She indicated she preferred to investigate the bruise to attempt to determine the origin and report only if the origin could not be identified. When asked if she completed the investigations prior to notifying the SA the DON stated "sometimes."

Background Studies:

Review of the personnel records identified the following information:

NA-J was hired on 9/2/2011. A hand written note completed by the DON dated 9/22/11, indicated the facility had received a background study from the State of Minnesota and NA-J was not to be working with vulnerable individuals. The personnel record lacked further documentation related to NA-J's background study.

NA-A was hired on 4/25/14. The personnel record did not contain a background study.

NA-D was hired on 12/12/13. A background study was completed on 11/21/13, which indicated the facility may or may not wish to allow the staff to provide care while the study was being completed. The personnel record did not include

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F 226	Continued From page 26 the final determination of the background study. DA-A was hired at the facility on 5/13/14. The personnel record did not contain a background study. On 6/26/14, at 2:00 p.m. the Administrator stated the background screenings had been completed by the former Administrator. He stated at this time, he was unable to gain access to the website which would allow him to determine if the staff members had passed their background screenings. He stated he had not been notified that the above staff members were not able to provide cares. In addition he stated NA-A and DA-A had worked at another facility owned by the same cooperation. He stated when the staff were hired a the facility a new background study was required, but stated he could not obtain the former facility background studies. On 6/26/14, at 2:10 p.m. the DON stated she could recall the situation related to NA-J and for a time she was unable to provide cares to the residents. She stated NA-J returned to the facility after the concern was cleared. The DON verified NA-J's personnel record did not contain documentation related to when she was cleared for employment. On 6/26/14, at 3:30 p.m. the Administrator provided information which indicated DA-A had passed a background study on 7/2/1996, and NA-A has able to provide care while the background study was being completed dated 11/20/12, (which was at former facility). The Administrator stated he had requested new background studies on all four employees to ensure compliance with the regulation.	F 226		

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide timely assistance with toileting in order to promote and maintain dignity for 1 of 1 resident (R30) who had requested toileting assistance which was not provided and resulted in an incontinent episode. Findings include: R30's quarterly Minimum Data Set (MDS) dated 3/31/14, indicated R30's diagnoses included Parkinson's disease, anxiety and dominant side hemiplegia (paralysis of the arm, leg and trunk on the same side of the body). The MDS also indicated R30 had intact cognition, was occasionally incontinent of urine and required extensive assist of one person with transfers and toilet use. R30's care plan dated 1/8/14, indicated R30 required staff assistance with transfers on / off the commode or toilet and directed staff to assist R30 to toilet every 2-3 hours and as needed and to assist with using the urinal as he chooses. On 6/24/14, at 1:49 p.m. R30 stated that when he puts his call light on for assistance, staff will come in and turn off his light and say they will be back but they don't return for up to an hour later. R30	F 241	1.R30 Interviewed by the Administrator and was encouraged to report and/or document any similar occurrences. 2. Administrator or Designee encouraged all residents at Resident Council meetings to immediately bring forward similar instances to ensure appropriate corrective action. 3. Updated policy and procedure on call light protocols. All staff has been educated on residents rights related to dignity. 4. DON or Designee will audit call light times qshift for 7 days (R30, and 3 random residents) moving to twice a week for 4 weeks qshift and to continue until 100% compliance has been achieved to ensure appropriate response times. Additionally, Resident satisfaction surveys will be conducted. Findings will be reported to QAA for recommendation & review.	8/6/14

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F 241	Continued From page 28 stated that one month previous, after supper on the evening shift, he put his call light for assistance to urinate. He stated the call light was turned off twice by staff without assistance being provided. R30 stated he had to "pee" in his pants due to waiting so long for staff and stated it was "disgusting." On 6/27/14, at 1:55 p.m. the director of nursing (DON) verified the incident reported by R30 was not a dignified experience for him and stated it should not have occurred. The DON confirmed it was important to meet R30's needs in a timely manner when he put his call light on. A policy regarding resident dignity was requested but none was provided.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were provided the opportunity to make choices related to bathing schedules for 2 of 3 residents (R16, R19) reviewed for choices and who had preferred a different bathing schedule.	F 242	1.R16 and R19 have been interviewed and provided the opportunity to choose bathing schedule. 2. Reviewed and updated resident preference sheet. All residents have been re-interviewed in regards to their bathing preferences. 3. Resident Right policy reviewed and	8/6/14

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F 242	Continued From page 29 Findings include: R16 was not provided the opportunity to determine her own bathing schedule. R16's quarterly Minimum Data Set (MDS) dated 2/20/14, indicated R16 was diagnosed with osteoarthritis, had intact cognition and required extensive assistance with bathing. R16's care plan dated 3/5/14, directed staff to assist with a weekly bath. R16's ADL (activities of daily living) Preference Questionnaire dated 5/21/14, included questions related to where R16 wished to receive personal cares and whether she wanted to receive cares at the bedside or in the bathroom. However, the questionnaire did not give R16 the opportunity to pick her own bath day. On 6/23/13, at 7:00 p.m. R16 confirmed she received a weekly bath. However, she explained that every Tuesday a local beautician visited the facility in which R16 paid the beautician to have her hair set every week. However, R16 stated her weekly bath was on Wednesdays so he hair only looked good for one day. R16 stated she wished she could pick a different day to receive her bath so her hair would be clean when the beautician was at the facility and she would be able to look good for longer than one day. On 6/24/14, at 10:30 a.m. (Tuesday) R16 was observed in the beauty shop having her hair set by the beautician. On 6/25/14, at 10:13 a.m. the activity director stated she did not ask the residents about their	F 242	updated if necessary. All staff educated on updated resident right policies. 4. All residents have been re-approached regarding resident preference sheet including bathing preferences and at least quarterly or as needed. Findings will be reported to QAA for recommendation & review.	

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F 242	Continued From page 30 bathing preference. On 6/25/14, at 11:45 a.m. the director of nursing (DON) stated the residents were added to the bath schedule according to the prearranged schedule which had been developed according to resident room numbers. She stated when a new resident was admitted to the facility, they were simply added to the bath schedule according to their assigned room numbers. She confirmed at no time were the residents given the opportunity to choose their own day to have a bath. When R16's request to have a weekly bath before the beautician visited the facility was explained to the DON, the DON stated she could change the bath schedule to accommodate the request. R19 had not been given the opportunity to determine her own bathing schedule R19's significant change MDS dated 4/27/14, indicated R19 was diagnosed with Parkinson's disease and a stroke with left sided paralysis. The MDS also indicated R19 had moderate cognitive impairment and was totally dependent on staff for all activities of daily living. The MDS indicated it was very important for R19 to make decisions about bathing. R19's care plan dated 4/30/2014, directed staff to assist R19 with a weekly shower. On 6/23/13, at 4:00 p.m. R19 stated she would like to take a bath 2-3 times a week. She stated while at the facility she received one bath a week. Review of the current undated bathing schedule, indicated R19 received a weekly shower on	F 242		

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F 242	Continued From page 31 Friday afternoons. On 6/26/13, 9:17 a.m. the DON confirmed R19 received a bath once a week on Friday afternoons. She reviewed R19's clinical record and reported R19's record did not contain a questionnaire regarding a bath schedule. She stated she would talk to R19 to determine when an additional bath could be scheduled. A policy regarding resident bathing schedules was requested and none was provided.	F 242		
F 244 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon resident grievances in regards to the provision of rehabilitation program services for 2 of 3 residents (R19, R32), interviewed regarding resident council grievances / concerns. Findings include: During interview on 6/24/14, at 8:00 a.m. R19 stated the resident council had discussed the restorative program services at the facility. She	F 244	1.R32 has been discharged. Refer to F282, R19. Resident Council Concern Follow up procedure has been reviewed with the facility IDT team for appropriate follow up responses. Administrator will audit to ensure timely response by department managers after every Resident Council Meeting. Findings will be reported to QAA for recommendation & review.	8/6/14

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stated staff do not assist with providing the restorative program services by doing them with residents as often as they are suppose to be completed.

During interview on 6/24/14, at 9:23 a.m. R32 stated the resident council had discussed the exercise programs/restorative nursing services at the facility. R32 stated the programs were not provided because sometimes the "girls don't come to work." R32 stated the council did not feel the nursing staff had responded to the concerns.

The Oakland Park Communities Monthly Resident Council Meeting minutes dated 5/5/14, indicated a concern form was given to the director of nursing (DON) regarding residents not receiving rehab (restorative services). The form also indicated one resident stated they had not received any restorative program services, although they should have been.

The Resident Council Concern/Follow-Up form dated 5/6/14, indicated the council had notified the nursing department one resident was not receiving restorative nursing as assessed. The form indicated the DON had responded to the council by indicating the resident audit sheets were reviewed and the "resident had refused for various times for various reasons."

The Oakland Park Communities Monthly Resident Council Meeting minutes dated 6/2/14, indicated an additional concern form was sent to the nursing department regarding the completion of the restorative nursing program. The minutes indicated the council was informed the reason why some of the programs were not provided was

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because the residents were refusing the therapy, or because the residents were working with occupational or physical therapy. In addition, the minutes indicated, "Maybe some are forgetting that they had received it or refused." Additionally, the minutes indicated the concern would be addressed with nursing "Right away."

The Resident Council Concern/Follow up form dated 6/2/14, indicated R19 and R32, and an additional resident, had indicated they were not receiving restorative therapy. The form also indicated the DON had responded on 6/3/14, by indicating she had reviewed the restorative documentation and identified the resident was refusing their therapy and had received the restorative program as directed.

On 6/25/14, at 12:30 p.m. the DON stated she was aware of the resident council concerns regarding the restorative program. She stated she had sent a response to the social service designee (SDD) regarding the concern but had not talked with the resident council members regarding the grievance.

On 6/26/14, at 11:28 a.m. the SSD stated each time the resident council identified a concern, a form was completed and sent to the appropriate department head. She stated the council did send concern forms to the DON regarding the restorative program, and the DON responded to the resident concerns. SSD stated the resident council seemed to be satisfied with the response from the DON.

During another interview on 6/26/14, at 1:55 p.m. the DON confirmed the resident council had expressed concerns with the restorative program

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F 244	Continued From page 34 during two different meetings. She stated she had reviewed the restorative nursing program documentation and it "Did not look bad." She stated she had not interviewed the residents, the nursing assistants, or completed audits to determine the root cause of the resident's ongoing concerns of not receiving their restorative program as ordered. She stated to her knowledge, she felt the concern was addressed. The facility Resident Council Concern Forms Policy and Procedure dated 8/2013, directed the SSD to complete a resident concern form with any concern identified during the meeting to attempt to determine the root cause of the concern, and to assist the resident's to find a resolution. The form was to be forwarded to the appropriate department manager who was to write and implement a resolution within 10 days of receiving the form. The resident council was then to determine if they felt the concern was resolved by signing the form. The 5/6/14, and the 6/2/14, concern forms had not been signed by the resident council members.	F 244		
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.	F 278		8/6/14

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F 278	Continued From page 35 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 observation, interview, and document review, the facility failed to ensure a resident's Minimum Data Assessment (MDS) accurately identified limitations in lower extremity range of motion (ROM) for 1 of 3 residents, (R18) reviewed for limitations in ROM / assessment accuracy. Findings include: R18's admission MDS dated 4/4/14, indicated R18 was diagnosed with dementia, had severely impaired cognition, and had no limitations in lower extremity ROM. R18's Rehab documentation note dated 3/24/14 written by the the director of nursing (DON),	F 278	1.R18s MDS has been reviewed and updated as needed. 2. All residents with ROM limitations have had their MDS reviewed and/or updated as needed. 3. Educate all members of the IDT team how to appropriately identify and document resident□s needs and dependencies. 4. Upon completion of full comprehensive assessments the IDT meets and reviews completed assessment to assure resident needs and dependencies are being addressed. Findings will be reported to QAA for recommendation & review.	

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F 278	Continued From page 36 indicated R18 was unable to stand, utilized a mechanical lift for transfers, and the residents ROM was within normal limits. The note further indicated R18 would continue to receive active, assistive, ROM exercises and passive ROM exercises to all extremities three times per week. On 6/25/14, at 7:15 a.m. nursing assistant (NA)-G and NA-D were observed assisting R18 to dress. R18 was observed to be unable to straighten the right knee, contracted (abnormal shortening of muscle tissue, rendering the muscle highly resistant to passive stretching). Both NAs confirmed R18's right knee would not straighten out. Both NA's stated R18 was admitted with the right knee contracture, which was unchanged. NA-D confirmed R18 received ROM exercises three times a week by the day shift NA. On 6/26/14, at 10:25 a.m. the DON stated she had made an "error" on the 4/4/14, admission MDS regarding limitations in ROM. The DON confirmed R18 had the right knee contractures when admitted to the facility.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		8/6/14

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F 279	Continued From page 37 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop the care plan to include physician ordered edema related interventions for 1 of 1 resident (R19) in the sample who had edema to the left hand. Findings include: R19's significant change Minimum Data Set (MDS) dated 4/27/14, indicated R19's diagnoses included Parkinson's disease and a stroke with left sided paralysis. The MDS also indicated R19 had moderate cognitive impairment and was totally dependent upon staff for all activities of daily living. R19's Physician's Orders dated 4/29/14, included an order for an edema glove to the left hand to be applied in the morning and removed in the evening. R19's care plan dated 4/30/14, did not address left hand edema nor interventions to minimize edema. On 6/23/14, from 4:00 p.m. until 8:00 p.m. R19 was not observed wearing a left hand edema glove. On 6/24/14, from 8:00 a.m. until 4:40 p.m. R19 was not observed wearing a left hand edema	F 279	1.R19□s care plan has been reviewed and interventions put into place. 2. All residents with physician ordered edema related interventions have had their care plans reviewed and updated as needed. 3. Review and/or revise comprehensive care plan policy. All nurses have been educated on proper care plan development. 4. All residents with physician ordered edema related interventions have had their care plans reviewed as needed. Findings will be reported to QAA for recommendation & review.	

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F 279	Continued From page 38 glove. On 6/25/14, from 6:30 a.m. until 3:00 p.m. R19's left hand was observed to be swollen and painful when moved. In addition, R19 was not observed wearing a left hand edema glove. On 6/26/14, at 9:50 a.m. the director of nursing (DON) confirmed R19 was to be wearing a left hand edema glove and the left arm was also to be elevated. The DON then entered R19's room and assessed R19's hand. She confirmed the left hand was swollen. The DON proceeded to open R19's bottom nightstand, dresser drawer and retrieved the edema glove. The DON was observed to apply the glove onto R19's left hand and stated the compression glove was to be used to minimize R19's hand swelling. In addition, the DON stated she was not aware staff were not applying the glove as ordered. A policy related to the development of care plans was requested, none was provided. .	F 279		
F 282 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written care plan for 2 of 3 residents (R21, R20), who required assistance with ambulation. In addition, the facility failed to provide range of motion (ROM) services	F 282	1.R21, R20, R18, R5, R20, R19, R2 care plans have been reviewed and are current. 2. All residents with nursing rehab programs have been reviewed and updated as needed. 3. Nursing Rehab, Grooming, and timely repositioning	8/6/14

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F 282	Continued From page 39 for 3 of 3 residents (R18, R5, R20), in the sample who required assistance with range of motion. Also, the facility failed to provide timely repositioning for 1 of 3 residents (R19), who required assistance with repositioning, and failed to provide grooming assistance for 1 of 3 resident's (R2), who required assistance with grooming. Findings include: R21 did not receive ambulation assistance as directed by the care plan. R21's care plan dated 4/17/14, indicated R21 directed staff to ambulate R21 with assistance of one staff and a front wheeled walker. R21's weekly schedule for rehabilitation form indicated R21 was to ambulate 5 days a week on the evening shift. R21's The Restorative Nursing Flow sheet documentation form indicated R21 was offered ambulation as follows: January 2014, out of 20 opportunities, R21 received ambulation 6 times. February 2014, out of 20 opportunities, R21 received ambulation 9 times. March 2014, out of 20 opportunities, R21 received ambulation 16 times. April 2014, out of 20 opportunities, R21 received ambulation 15 times. May 2014, out of 22 opportunities, R21 received ambulation 22 times. June 2014, out of 18 opportunities, R21 received ambulation 5 times.	F 282	policies have been reviewed and updated as needed. All staff educated on updated policies and procedures. 4. DON or Designee will conduct Nursing Rehab, female facial hair, and timely repositioning audits are to be completed weekly x4 weeks then bimonthly for one month moving to monthly. Findings will be reported to QAA for recommendation & review.	

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F 282	Continued From page 40 On 6/25/14, at 11:17 a.m. the DON confirmed R21 was to receive ambulation five times a week. and stated R21's care plan related to ambulation was not followed as directed. R20's care plan dated 6/11/4, indicated R20 received restorative program services as directed. R20's Restorative Care Program form dated 1/14/13, indicated R20 was to ambulate six to seven times per week to maintain bilateral lower extremity strength for transfers and ambulation. The from directed staff to ambulate R20 with a right platform wheeled walker 30-120 feet, daily R20's Restorative Nursing Flow Sheet from June 1st- June 26th, 2014 indicated out of 26 opportunities, R20 received ambulation assistance only 7 times. There were no resident refusals to ambulate documented. ON 6/24/14, R20 was observed from 1:10 p.m. until 3:30 p.m. and was not observed to ambulate. -At 2:08 p.m. when asked if she was assisted to ambulate, R20 shrugged her shoulders and shook her head no. When asked if staff were supposed to help her with ambulation R20 shook her head yes. -At 2:31 p.m. NA-K confirmed staff were supposed to assist R20 with ambulation, however, stated the facility did not have enough staff in order to complete ambulation for R20. On 6/25/14, at 7:27 a.m. when asked if she had received ambulation assistance last evening R20	F 282		

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F 282	Continued From page 41 shook her head no. -At 1:25 p.m. the DON confirmed R20 was to receive ambulation services six to seven times a week. The DON verified R20 did not receive ambulation assistance as directed by the care plan. The facility's Promote Optimal Body Functioning policy dated 3/13, indicated residents were to receive assistance with ambulation according to their care plan. R18's care plan dated 4/9/14, indicated staff were to follow R18's rehab program plan. R18's weekly schedule for Rehabilitation Forms indicated R18 was to receive passive range of motion (PROM) to all extremities 3 days a week on Monday, Tuesday, and Friday, on the day shift. R18's Restorative Nursing Flow Sheet forms were reviewed and revealed the following: March 2014, Out of 2 opportunities, R18 received no ROM services. April 2014, Out of 12 opportunities, R18 received ROM services 6 times. May 2014, Out of 12 opportunities, R18 received ROM services 12 times. June 2014, Out of 9 opportunities, received ROM services 6 times. R18's Rehab documentation note dated 3/24/14, written by the DON indicated R18 would continue to receive active assistive ROM exercises and passive ROM exercises to all extremities three times per week.	F 282		

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F 282	Continued From page 42 On 6/25/14, at 7:15 a.m. nursing assistant (NA)-G and NA-D were observed to assist R18 to dress. NA-D confirmed R18 was to receive ROM exercises three times a week by the day shift NA. On 6/26/14, at 10:17 a.m. NA-D stated R18's ROM was not documented because if the day shift did not have time to do it, then the evening shift was supposed to do the ROM, and stated the lack of documentation could be because the NAs forgot to chart. However, there was no indication if the ROM was not being completed or just not documented. At 10:25 a.m. the DON stated R18 was to receive ROM to all extremities three times per week and confirmed R18 was not receiving ROM services as directed by the care plan. R5's care plan dated 3/5/14, directed staff to assist R5 with range of motion services as outlined in the therapy notes. R5's physical therapy (PT) restorative plan form dated 3/11/14, directed staff to promote bilateral lower extremity strength to assist with function mobility and transfers. The form provided ROM instructions and indicated R5 was to be seated while completing the following exercise, two rounds with ten repetitions each three times a week: -Right leg: R5 was to complete hip flexion with no weight. Knee extensions with a two pound weight, knee flexion with an orange theraband (elastic resistant bands), hip abduction with a maroon theraband and hip extension with a maroon theraband. -Left Leg: was to receive hip flexion with a two	F 282		

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pound weight, knee extension with a two pound weight, knee flexion with a maroon theraband, hip abduction with a maroon theraband and hip extension with a maroon theraband. The form also indicated R5 was also to receive bilateral heel cord and hamstring stretches for 30 seconds times three repetitions.

R5's occupational therapy program dated 3/13/14, directed staff to maintain and promote upper extremity function for activities of daily living participation. The form directed staff to perform the following range of motion exercise three times a week:
-use a yellow theraband for two sets of ten repetitions for biceps curls, triceps press and internal rotation and were also directed to provide a one pound wand for two sets of 15 repetitions for shoulder flexion, chest press and forward and backward circles.

On 6/25/14, at 9:43 a.m. NA-C was observed to provide ROM services to R5. However, during the observation, at not time was R5 observed to fully extend her shoulders nor was NA-C observed to cue R5 to stretch her arms. Throughout the observation, NA-C was not observed to utilize therabands while completing the upper body range of motion.

At 9:46 a.m. NA-C was observed providing lower extremity ROM exercises. However, R5 was not observed to fully extend her knees during the exercises. At 9:48 a.m. NA-C removed R5's shoes and directed R5 to move her feet up and down. At no time was NA-C observed to hold R5's feet in an attempt to complete heel cord or hamstring stretches. In addition, NA-C was not observed to utilize theraband or weights during

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the lower extremity range of motion program. At 9:49 a.m. (six minutes later) NA-C left the room as ROM exercises were complete.

On 6/25/14, at 9:52 a.m. NA-C stated the only adaptive equipment used for exercise programs was the one pound weighted bar for the female residents and a three pound weighted bar for the men.

On 6/25/14, at 12:00 p.m. NA-C confirmed she had not completed the program as written by the therapists and stated she did not feel she had enough time to complete the entire program.

On 6/25/14, at 12:15 p.m. the DON confirmed R5 had not received ROM as directed by the care plan.

R20's care plan dated 6/11/4, indicated R20 had right sided weakness and directed staff to provide restorative program services as directed.

R20's Restorative Care Program form dated 1/14/13, indicated R20 was to receive AROM three times per week to maintain bilateral lower extremity strength. The form indicated R20's program was to include lower extremity standing exercises in a right platform wheeled walker x 10 repetitions as well as marches, hip abduction, squats and heel and toe raises.

R20's Restorative Care Program form dated 1/17/13, indicated R20 was independent with upper extremity exercises and included a formal exercise program for R20 to follow.

R20's Restorative Nursing Flowsheet

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documentation forms for lower extremity AROM from June 1st- June 26th, 2014 were reviewed and indicated out of 26 opportunities, R20 received AROM services 3 times.

ON 6/24/14, R20 was observed from 1:10 p.m. until 3:30 p.m. and was not observed to receive ROM services.

-At 2:08 p.m. R20 was observed in bed. When R20 was asked if staff assisted with lower extremity AROM exercise, R20 shrugged her shoulders and shook her head no. When asked if staff were supposed to help her with the exercises, R20 shook her head yes.

-At 2:31 p.m. NA-K confirmed staff were supposed provide R20's lower extremity AROM exercises, however, stated the facility did not have enough staff all the time in order to get everything done.

R19's care plan dated 4/30/14, directed staff to assist with repositioning every 2-3 hours.

On 6/25/14, at 6:55 a.m. R19 NA-C and NA-G were observed to assist R19 from the commode and into the wheelchair R19 was observed to remain in the wheelchair until 10:36 a.m. (three hours and 40 minutes later) at which time NA-C and NA-D were observed to transfer R19 onto the commode. R19's skin was observed intact and free from redness. R19's wheelchair was observed to be equipped with a pressure redistribution cushion. .

On 6/25/14, at 10:40 a.m. NA-C confirmed R19 had last been assisted with repositioning at 6:55 a.m. a total of 3 hours and 40 minutes earlier.

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F 282	Continued From page 46 On 6/26/14, at 10:00 a.m. the DON stated R19 should have received repositioning assistance every two to three hours as directed by the care plan. R2's care plan dated 2/5/14, indicated staff were to check for facial hair on R2's bath day and directed staff to assist R2 with shaving with the use of an electric razor as needed and as R2 requested. The care plan further directed staff to document R2's refusals to shave. On 6/24/14, at 10:58 a.m. R2 was observed seated in her room, in a chair by the window. R2 was observed to have facial hair approximately 1/4 inch in length on her chin and upper lip. On 6/26/14, at 9:40 a.m. R2 was observed in her room, seated in a chair by the window. R2's upper lip and chin facial hair remained. R2 stated she did not like the facial hair on her face and would like them taken off. On 6/26/14, at 1:38 p.m. NA-G stated shaving / facial hair removal was part of the grooming services provided on bath day for both men and women. NA-G confirmed R2's bath day was on Mondays and stated R2's facial hair should have been removed the previous Monday. On 6/26/14, at 2:43 p.m. the DON confirmed R2 should have been shaved on her bath day and stated she would expect the care plan to be followed regarding grooming. A policy regarding care plan implementation related to ROM, repositioning, and grooming was	F 282		

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F 282	Continued From page 47 requested but none was provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide proper wheelchair positioning for 1 of 1 resident (R21) reviewed with positioning needs. In addition, the facility failed to provide a compression glove for 1 of 1 resident (R19) who had hand swelling. Findings include: R21's annual Minimum Data Set (MDS) dated 1/20/14, indicated R21 had a diagnoses of schizophrenia, had severe cognitive impairment, and was independent with wheelchair locomotion. R21's quarterly MDS dated 4/14/14, also indicated R21 was independent with wheelchair locomotion. During observation on 6/25/14, at 7:00 a.m. R21 was wheeling herself from the nurses station to the entrance doors of the dining room in her wheelchair using her feet to propel. -At 7:44 a.m. R21 was observed wheeling herself into the dining room.	F 309	1.R21 has received OT referral for wheelchair positioning and is currently receiving active treatment for wheelchair positioning. See F279, R19. 2. All residents that require a wheelchair for mobility will be reviewed for sitting posture. 3. Individual residents utilizing wheelchairs will have their seating status reviewed at least quarterly and PRN as needs arise. Findings will be reported to QAA for recommendation & review.	8/6/14

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F 309	Continued From page 48 -At 8:12 a.m. R21 was observed seated at the dining room table. R21 remained in the wheelchair, however, her buttocks had slid down in the chair which created an approximate one foot distance between her and the dining room table. R21 was observed having to stretch forward in order to reach the hot cereal which was placed on the table in front of her. R21's wheelchair brakes were unlocked which resulted in the wheelchair wheels moving as R21 was attempting to reach her food and feed herself. -At 8:13 a.m. R21 was observed attempting to boost herself up in the wheelchair, however, was unable to get herself in an erect, upright position. While R21 was reaching for her food in an attempt to feed herself the resident was spilling scrambled eggs on her shirt, and hot cereal on her clothing protector. -At 8:25 a.m. R21 was observed independently propelling her wheelchair with her feet as she exited the dining room. -At 8:32 a.m. R21 was observed stationed in front of the nurses station, asleep in her wheelchair. R21 had slid down in her wheelchair with the back of her head resting on the top portion of the back of the wheelchair. -At 8:44 a.m. R21 was observed in the same position, asleep, with her head hung backwards slid down in her wheelchair. -At 8:52 a.m. R21 was observed independently propelling her wheelchair with her feet into her room. On 6/25/14, at 1:41 p.m. the director of nursing (DON) stated she was aware R21 slid down in her wheelchair, and felt the resident slid down due to self propelling the wheelchair with her feet. On 6/26/14, at 8:40 a.m. R21 was observed near	F 309		

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F 309	Continued From page 49 the nurses station in the hallway in her wheelchair. R21 was self propelling her wheelchair using her feet and returned to her room. R21's buttocks had slid forward in her wheelchair, and her buttocks were approximately eight inches from the back of the wheelchair seat. R21 had no cushion in her wheelchair, however, she was able to boost herself up in the chair to a straighter position. -At 10:00 a.m. R21 was observed in her wheelchair with her buttocks positioned away from the back of the seat. The occupational therapist (OT)-A stated R21 would definitely benefit from a wheelchair cushion to assist the resident to stay in an upright position. R21 stated the reason she slides down while in the wheelchair was because the "seat was slippery". R21 stated she tried to reposition herself in the chair. OT-A stated the facility wanted R21 to remain independent with her wheelchair mobility. A policy related to wheelchair positioning was requested but not provided. R19 did not receive appropriate care and services for left hand edema. The significant change MDS dated 4/27/14, identified R19 had moderate cognitive impairment and diagnoses including Parkinson's disease, depression, and history of a stroke with left sided paralysis. The MDS identified R19 was totally dependent upon staff for all activities of daily living. R19's care plan dated 4/30/14, did not address left hand edema or interventions to minimize edema. The Physician's Orders dated 4/29/14, included an order for an edema glove to the left hand be	F 309		

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applied in the morning, and removed in the evening.
On 6/23/14, at 5:00 p.m. R19's left hand was observed to be swollen. R19 did not have an edema glove. R19 stated she was unable to move her left following her stroke.
On 6/24/14, at 8:00 a.m. R19's left hand was observed to be swollen. The resident was not wearing the edema glove.
On 6/25/14, at 6:44 a.m. nursing assistant (NA)-C assisted R19 with morning cares. R19's left hand was observed to be swollen and the fingers were curled towards the palm. She was not able to move the fingers and the resident told NA-C her hand hurt when NA-C opened her fingers to allow NA-C to wash the palm of her hand. At no time was NA-C observed to apply an edema glove.
On 6/25/14, at 8:00 a.m. R19 was observed being wheeled into the dining room. The resident's left hand continued to be swollen and her fingers were curled into her palm. The resident did not have the edema glove on.

On 6/25/14, at 10:43 a.m. NA-C assisted R19 to use the commode. R19 informed NA-C her hand was, "Sore today."

On 6/25/14, at 12:15 p.m. licensed practical nurse (LPN)-A stated she was aware of increased edema/swelling in R19's left hand. She stated she had notified the physician of the concern and was awaiting a response from the physician.

On 6/25/14, at 1:50 p.m. R19 was observed receiving range of motion to the left hand. R19 stated the hand was sore. R19 did not have an edema glove.

On 6/25/14, at 2:04 p.m. NA-B stated R19 had

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F 309	Continued From page 51 told her that her left hand was sore when it was moved. During interview on 6/26/14, at 8:45 a.m. LPN-C stated she had been notified by staff R19's hand was more swollen, and LPN-C had informed the physician. LPN-C stated she was waiting to hear back from the physician. Review of a Clinic Fax dated 6/24/14, indicated the facility had informed the physician R19's left hand was, "Swollen/puffy". The hand had 2 plus pitting edema, and R19 had informed the staff it hurt when she moved her fingers. The physician responded back to the facility concerns with, "Observe." LPN-C stated the staff were just to watch the hand and elevate if needed. On 6/26/14, at 9:50 a.m. the DON stated R19 was to wear a left hand edema glove and elevate the hand. The DON entered R19's room and assessed R19's hand. She opened the bottom drawer of R19's night stand and removed the edema glove and placed it on R19's hand and stated the resident was to be utilizing the compression glove daily to minimize left hand swelling. She stated she was not aware staff had not been applying the glove as ordered. A policy regarding edema gloves was requested and not provided.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311		8/6/14

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F 311	Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with ambulation services for 2 of 3 residents, (R21, R20) who required assistance with ambulation. In addition, the facility failed to provide range of motion (ROM) services for 2 of 3 residents (R20, R18) reviewed for ROM. Findings include: R21's annual Minimum Data Set (MDS) dated 1/20/14, indicated R21 was diagnosed with schizophrenia, had severe cognitive impairment, and required limited assistance with ambulation in the corridor. R21's Fall Care Area Assessment (CAA) dated 1/22/14, indicated R21 was to ambulate with staff daily and was at high risk for falls. R21's care plan dated 4/17/14, indicated R21 was to ambulate with one staff assist and a front wheeled walker. The weekly schedule for rehabilitation form indicated R21 was to ambulate five days a week, on the evening shift. R21's Restorative Nursing Flow sheet documentation form indicated R21 was offered ambulation as follows: January 2014, out of 20 opportunities, R21 received ambulation 6 times. February 2014, out of 20 opportunities, R21 received ambulation 9 times. March 2014, out of 20 opportunities, R21 received ambulation 16 times.	F 311	1.Refer to 282: R21,R20,R18	

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F 311	Continued From page 53 April 2014, out of 20 opportunities, R21 received ambulation 15 times. May 2014, out of 22 opportunities, R21 received ambulation 22 times. June 2014, out of 18 opportunities, R21 received ambulation 5 times. On 6/25/14, at 11:17 a.m. the director of nursing (DON) stated R21 was to receive ambulation five times a week. and. The DON confirmed R21's had not been ambulated five times per week as assessed. R20's quarterly MDS dated 6/12/14, indicated R20 was diagnosed with a stroke with right sided weakness, had no cognitive impairments, and had functional limitation in range of motion (ROM) to the right side upper and lower extremities. R20's care plan dated 6/11/4, indicated R20 was at high risk for falls due to the stroke with left sided weakness. The care plan also indicated R20 received restorative program services as directed. R20's Restorative Care Program form dated 1/14/13, indicated R20 was to ambulate six to seven times per week to maintain bilateral lower extremity strength for transfers and ambulation. The form directed staff to ambulate R20 with a right platform wheeled walker 30-120 feet and perform bilateral hamstring stretches X2 with 30 second holds, daily. R20's Restorative Nursing Flow Sheet for June 2014, indicated for June 1st- 26th, the resident received ambulation assistance seven times out of the 26 opportunity's to ambulate. There were	F 311		

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F 311	Continued From page 54 no resident refusals to ambulate documented. On 6/24/14, resident was observed from 1:10 p.m. until 3:30 p.m. and was not observed to ambulate. -At 2:08 p.m. when asked if she was assisted to ambulate, R20 shrugged her shoulders and shook her head no. When asked if staff were supposed to help her with ambulation R20 shook her head yes. -At 2:31 p.m. NA-K confirmed staff were supposed to assist R20 with ambulation, however, stated the facility did not have enough staff all the time in order to get everything done. On 6/25/14, at 7:27 a.m. when asked if she had received ambulation assistance last evening R20 shook her head no. -At 1:25 p.m. the DON confirmed R20 was to receive ambulation services six to seven times a week. The DON verified R20 did not receive ambulation assistance as directed. The Promote Optimal Body Functioning policy dated 3/13, indicated residents were to receive assistance with ambulation according to their care plan. R20's care plan dated 6/11/14, indicated R20 had right sided weakness and directed staff to provide restorative program services as directed. R20's Restorative Care Program form dated 1/14/13, instructed R20 was to receive active assist ROM (AAROM), three times per week, to	F 311		

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maintain bilateral lower extremity strength. The form indicated R20's program was to include lower extremity standing exercises in a right platform wheeled walker x 10 repetitions as well as marches, hip abduction, squats, and heel and toe raises.

R20's Restorative Care Program form dated 1/17/13, indicated R20 was independent with upper extremity exercises and included a formal exercise program for R20 to follow.

R20's Restorative Nursing Flowsheet documentation forms for lower extremity AAROM for June1st- June 26th, 2014, identified out of 26 opportunities, R20 received AAROM services only three times. There was no documentation of resident refusals.

On 6/24/14, R20 was observed from 1:10 p.m. until 3:30 p.m. and was not observed receiving any ROM services.

-At 2:08 p.m. R20 was laying in bed and was able to independently raise and lower both legs several times, without difficulty. When R20 was asked if staff assisted with lower extremity AAROM exercise, R20 shrugged her shoulders and shook her head no. When asked if staff were supposed to help her with the exercises, R20 shook her head yes.

-At 2:31 p.m. NA-K confirmed staff were supposed to provide R20's lower extremity AAROM exercises, however, she stated the facility did not have enough staff to complete the ROM services daily.

R18's admission MDS dated 4/4/14, identified

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R18 had diagnoses including dementia, had severe cognitive impairment, had no limitations in range of motion (ROM) to upper or lower extremities, and was totally dependent upon staff for all activities of daily living.

R18's care plan dated 4/9/14, indicated R18 had a rehab program, however, the care plan did not identify the specific program.

The weekly schedule for rehabilitation services indicated R18 was to receive passive range of motion (PROM) to all extremities three days a week on Monday, Tuesday, and Friday, during the day shift.

R18's Rehab documentation note dated 3/24/14, which was written by the DON, indicated R18 was unable to stand, utilized a mechanical lift for transfers, and all ROM was within normal limits. The note further indicated R18 would continue to receive active, assistive, ROM exercises, and passive ROM exercises to all extremities three times per week.

R18's Restorative Nursing Flow Sheets from March 2014 through June 2014, indicated ROM services were offered as follows:

March 2014,-Out of two opportunities, received no ROM.
April 2014,-Out of 12 opportunities, received ROM 6 times.
May 2014,-Out of 12 opportunities, received ROM 12 times.
June 2014,- Out of 9 opportunities, received ROM 6 times.

On 6/25/14, at 7:15 a.m. nursing assistant (NA)-G

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 57 and NA-D were observed assisting R18 getting dressed. R18 was unable to straighten the right knee, which appeared contracted (abnormal shortening of muscle tissue, rendering the muscle highly resistant to passive stretching). Both NAs confirmed R18's right knee would not straighten. Both NAs stated R18 was admitted with a right knee contracture, which had not changed. NA-D confirmed staff on the day shift were directed to assist R18 with ROM exercises three times a week. On 6/26/14, at 10:17 a.m. NA-D stated the reason ROM services were not documented was because if the day shift NA did not have time to do the ROM, the evening shift NA was to supposed to do it, however, there was no indication if the evening shift could have forgotten to chart regarding completing the ROM, or if it was not being completed. At 10:25 a.m. the DON confirmed R18 was scheduled to receive ROM exercises to all extremities three days a week on Monday, Tuesday, and Friday according to the rehab program identified on the care plan. The DON stated the Restorative Nursing Flow Sheets needed to be filled out accurately to determine if R18 was actually receiving ROM as assessed. At 1:22 p.m. NA-G stated R18 would assist with dressing himself, and felt he had enough ROM in upper extremities to touch the back of his head with both of hands. At 1:29 p.m. licensed practical nurse (LPN)-C encouraged R18 to touch the back of his head with both hands, which the resident was able to complete.	F 311		

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide grooming assistance for 1 of 1 resident (R2) who required assistance with removal of facial hair. Findings include: R2's annual Minimum Data Set (MDS) dated 4/28/14, indicated R2 was diagnosed with Alzheimer's disease, dementia and macular degeneration. The MDS also indicated R2 had severe cognitive impairment and required extensive assist of one staff for personal hygiene. R2's care plan dated 2/5/14, directed staff check R2 for facial hair on her bath day and to assist R2 with shaving facial hairs using an electric razor as R2 requested and as needed. The care plan further directed staff to document any resident refusals to shave. The Bath Schedule dated 6/17/14, indicated R2 was to have a bath and hair wash on Monday, day shift. The Bath Schedule directed staff to shave both men and women. On 6/24/14, at 10:58 a.m. R2 was observed seated in her chair in her room. R2's chin and	F 312	1.Refer to 282: R2	8/6/14

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F 312	Continued From page 59 upper lip facial hair were observed to be approximately 1/4 inch in length. On 6/25/14, at 6:40 a.m. R2 was observed dressed and seated in her wheelchair in the main lounge area. R2's chin and upper lip facial hair remained approximately 1/4 inch in length. On 6/26/14, at 9:40 a.m. R2 was observed in her room, seated in her easy chair by the window. R2's facial hair remained on her chin and upper lip. R2 stated she did not like the facial hair on her face and would like them taken off. On 6/26/14, at 1:38 p.m. nursing assistant (NA)-G confirmed shaving / facial hair removal was part of the grooming services provided on bath day for both men and women. NA-G also confirmed R2's bath day was Monday and stated her facial hair should have been removed the previous Monday. On 6/26/14, at 2:43 p.m. the director of nursing (DON) confirmed R2 should have been shaved on her bath day and stated she would expect the care plan to be follow regarding grooming. The Shaving of Facial Hair policy dated 6/2005, instructed staff female residents would be viewed by the direct caregiver weekly on their bath day, for the presence of facial hair on their chin, neck, cheeks and under the nose and would be shaved as needed.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		8/6/14

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F 314	Continued From page 60 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R19) who was identified as being at risk for developing pressure ulcers, received the necessary care and treatment as assessed by the facility to prevent pressure ulcers from developing. Findings include: R19's significant change Minimum Data Set (MDS) dated 4/27/14, identified R19 had moderate cognitive impairment and diagnoses including Parkinson's disease, depression, and history of a stroke with left sided paralysis. The assessment identified R19 as being totally dependent upon staff for all activities of daily living. The assessment also identified R19 at risk for the development of pressure ulcers. R19's pressure ulcer Care Area Assessment (CAA) dated 4/30/14, identified the resident was at risk for pressure ulcer development. The facility Braden Scale for Prediction Pressure Sore Risk assessment dated 4/27/14, identified R19 was at high risk for the development of pressure ulcers. The Tissue Tolerance Testing (tissue perfusion assessment) dated 5/1/14,	F 314	1.Refer to F282: R19	

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F 314	Continued From page 61	F 314		

indicated R19 was able to tolerate sitting up in the chair for three hours.

R19's care plan dated 4/30/14, directed staff to assist the resident with repositioning every 2-3 hours.

During observation on 6/25/14, at 6:55 a.m. R19 was transferred from a commode to a wheelchair with assistance of two nursing assistants, (NA)-C and NA-G. R19 was then wheeled out to the main lobby and positioned in front of the television. R19 remained in front of the television in the wheelchair until 8:00 a.m. at which time the social service designee (SSD) wheeled R19 to the dining room. R19 remained in her wheelchair during the entire breakfast meal. At 8:48 a.m. NA-D wheeled R19 back to her room. At no time was R19 assisted to reposition. R19 remained in the wheelchair in her room until 10:20 a.m. at which time the activity director wheeled R19 toward the activity room for morning activities. At 10:27 a.m. R19 stated she had not been assisted to the restroom since she had gotten out of bed and asked the activity director to assist her to the rest room.

At 10:31 a.m. NA-C wheeled R19 to her room. She stated she could not assist R19 without additional help and would come back to find more assistance.

At 10:36 a.m. NA-C and NA-D assisted R19 to stand. R19's wheelchair had a pressure redistribution cushion and her skin was observed to be free of reddened areas.

On 6/25/14, at 10:40 a.m. NA-C confirmed R19 had last been assisted with repositioning at 6:55

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F 314	Continued From page 62 a.m. which was a total of 3 hours and 40 minutes the resident had remained in her wheelchair without being repositioned. On 6/26/14, at 10:00 a.m. the director of nursing (DON) stated the resident had been assessed to receive assistance with repositioning every 2-3 hours, as directed by the plan of care. The facility Pressure Ulcer Risk Assessment policy dated 5/2012, directed the staff to assist the resident according the the Pressure Ulcer Risk assessment to promote the prevention of pressure ulcer development.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide range of motion (ROM) services to prevent further decrease in range of motion (ROM) for 2 of 3 residents (R18, R5) in the sample who had limitations in range of motion. Findings include: R18's admission Minimum Data Set (MDS) dated	F 318	1.Refer to 282, R18,R5	8/6/14

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F 318	Continued From page 63 4/4/14, indicated R18 was diagnosed with dementia and had severe cognitive impairment and had no lower extremity limitations in ROM. R18's care plan dated 4/9/14, indicated R18 was involved in a rehab program and directed staff to follow it. R18's weekly schedule for rehabilitation indicated R18 was to receive passive ROM (PROM) to all extremities 3 days a week on Monday, Tuesday and Fridays, on the day shift. R18's Rehab Documentation note dated 3/24/14, and written by the director of nursing (DON), indicated R18's ROM was within normal limits, therefore, R18 would continue to receive active assistive ROM exercises and passive ROM exercises to all extremities three times per week. R18's Restorative Nursing Flow Sheet forms from March 2014, through June 2014, were reviewed and revealed the following: March 2014, Out of 2 opportunities, R18 received no ROM services. April 2014, Out of 12 opportunities, R18 received ROM services 6 times. May 2014, Out of 12 opportunities, R18 received ROM services 12 times. June 2014, Out of 9 opportunities, received ROM services 6 times. On 6/25/14, at 7:15 a.m. nursing assistant (NA)-G and NA-D were observed to assist R18 to dress. R18's right knee was observed to be unable to straighten. Both NAs stated R18's right knee would not straighten out and was contracted (abnormal shortening of muscle tissue, rendering	F 318		

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F 318	Continued From page 64 the muscle highly resistant to passive stretching) and was unchanged from admission. NA-D stated R18 received ROM three times a week by the day NA. -At 7:21 a.m. NA-D and NA-G were observed to transfer R18 into the wheelchair via a mechanical lift. At 7:27 a.m. R18 was observed seated in the wheelchair. R18's right knee was bent with his right foot resting on a strap positioned across the front of the wheelchair. On 6/26/14, at 10:17 a.m. NA-D stated the reason residents' ROM was not documented was because if the day shift did not have time to do it, then the evening shift was to supposed to do it and stated the lack of documentation could be because the NAs forgot to chart. At 10:25 a.m. the director of nursing (DON) stated she had made an "error" when completing R18's admission MDS on 4/4/14, regarding limitations in ROM. The DON confirmed R18 had the right knee contracture when admitted to the facility. The DON stated R18 was to receive ROM to all extremities three times per week and confirmed R18 was not receiving ROM services as directed by the care plan. The DON also stated the Restorative Nursing Flow Sheets were not getting filled out and she was having the NAs turn in audit forms which they documented on when ROM was provided. R5's significant change MDS dated 5/21/14, identified R5 as alert and oriented with diagnoses including diabetes mellitus, depression, anxiety and osteoarthrosis. The assessment indicated R5 required extensive assistance with all	F 318		

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F 318	Continued From page 65 activities of daily living, she was unable to ambulate and had functional limitations in range of motion in one lower extremity. The Activity of Daily Living Function/Rehabilitation potential care area assessment (CAA) indicated the resident had sustained an overall decline in her ability and staff were to provide assistance. The plan of care dated 3/5/14, directed the staff to assist the range of motion services as outlined in the therapy notes. The physical therapy (PT) restorative activities form dated 3/11/14, directed the staff to promote bilateral lower extremity strength to assist with function mobility and transfers. The instruction indicated R5 was to be seated and completed the following exercise two rounds with ten repetitions each three times a week. The right leg R5 was to complete hip flexion with no weight. Knee extensions with a two pound weight, knee flexion with an orange theraband (elastic resistant bands), hip abduction with a maroon theraband and hip extension with a maroon theraband. The left leg was to receive hip flexion with a two pound weight, knee extension with a two pound weight, knee flexion with a maroon theraband, hip abduction with a maroon theraband and hip extension with a maroon theraband. R5 was also to receive bilateral heel cord and hamstring stretches for 30 seconds for three repetitions. The occupational therapy program established on 3/13/14, directed the staff to maintain and promote upper extremity function for activities of daily living participation. The staff were to perform the following range of motion exercise	F 318		

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F 318	Continued From page 66	F 318		

three times a week. The staff were to use a yellow theraband two set of ten repetitions for biceps curls, triceps press and internal rotation. The staff were also to direct R5 to use a one pound wand for two sets of 15 repetitions for shoulder flexion, chest press and forward and backward circles.

Review of the Restorative Nursing Flow Sheets revealed the following information:
In June (1-26), 2014, R5 had received ROM 4 times out of 12 opportunities.
In April 2014, R5 had received ROM 11 out of 12 opportunities.
In May 2014, R5 had received ROM 8 times, she had refused 5 times and spent one day in the hospital.
In March 2014, R5 had received ROM 5 times out of 6 opportunities.

On 6/25/14, at 9:43 a.m. NA-C entered R5's room carrying a one pound bar. NA-C directed R5 to push the bar out ten times, lift the bard over her head ten times and move the bar up and down as if she were "shoveling snow." At no time was R5 observed to fully extend her shoulders, elbows or wrists. NA-C was not observed to cue R5 to stretch her arms. NA-C then cued R5 to move her wrists up and down and move her fingers. NA-C counted to ten with each exercise. NA-C was not observed to utilize therabands while completing the upper body range of motion.
At 9:46 a.m. NA-C cued R5 to life her heels up and down, then cued R5 to lift the right leg and draw circles in the air with her foot, she repeated the exercise with the left leg as NA-C counted to ten. R5 was not observed to fully extend her knees during the exercises. She then directed R5 to move her legs back and forth allowing her

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F 318	Continued From page 67	F 318		

knees to touch in an in and out direction. NA-C counted to ten. At 9:48 a.m. NA-C removed R5's shoes and directed R5 to move her feet up and down. At no time was NA-C observed to hold R5's feet in an attempt to complete heel cord or hamstring stretches. NA-C was not observed to utilize theraband or weights during the lower extremity range of motion program. At 9:49 a.m. (six minutes latter) NA-C left the room as ROM exercises were complete.

On 6/25/14, at 9:52 a.m. NA-C stated the only adaptive equipment used for exercise programs was the one pound weighted bar for the female residents and a three pound weighted bar for the men.

On 6/25/14, at 12:00 p.m. NA-C reviewed R5's range of motion program as written by the therapists. She stated she had not been trained on how to complete the exercises with therabands and did not know there were different color bands which would provide a different level of resistance. NA-C confirmed she had not completed the program as written by the therapists. NA-C added, she did not feel she had enough time to complete the programs.

On 6/25/14, at 12:15 p.m. the DON stated she reviewed the restorative sheets on a monthly basis. She stated R5 had a history of being resistive and refused to participate in the restorative program. The DON stated when she completes the restorative evaluations she monitors the flow sheet documentation and will occasionally observe the staff to ensure the program is being followed appropriately. She stated the nursing assistants working on the floor,

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F 318	Continued From page 68 train the new staff on how to compete the ROM programs. NA-C had been working at the facility for less than one month and had been trained by other NAs. The DON stated she had not had the opportunity to observe NA-C performing ROM and stated she was not aware NA-C was not using the exercise equipment as directed by the therapist nor did NA-C she direct the residents to fully extend their joints to obtain maximum stretching capacity. The DON confirmed R5 had not received ROM as directed by the care plan. A policy related to active range of motion was requested and none was provided. The General Policies dated 4/2014, indicated the restorative and rehabilitative nursing procedures are directed under the guidance of the physician.	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		8/6/14

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F 322	Continued From page 69 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to administer medications via gastrostomy tube (G-tube) individually with appropriate water flushes for 1 of 1 resident (R9) who received G-tube medications Findings include: R9's admission Minimum Data Set (MDS) dated 3/31/14, identified R9 had severe cognitive impairment and had diagnoses including gastrostomy (creation of an artificial external opening into the stomach for nutritional support or gastrointestinal compression), Parkinson's disease, esophageal reflux, stroke, hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (weakness on one side of the body) affecting dominant side. During observation on 6/25/14, at 8:33 a.m. licensed practical nurse (LPN)-A measured 15 milliliters (ml) of potassium chloride solution 10% into a graduated medication cup and poured it into a paper cup. She then added Prevacid 30 mg solutab (orally disintegrating tablets to reduce stomach acid) to the cup containing potassium chloride liquid. LPN-A then added into a second medication cup, furosemide 20 milligram (mg) tab (a diuretic), Lisinopril 10 mg tab (treats high blood pressure), sertraline 50 mg tab (antidepressant), Carbidopa/L-Dope 10-100 mg tab (treats Parkinson's disease), metoprolol 50 mg tab (treats high blood pressure), acetaminophen 325 mg 2 tabs. These tablets were crushed and put	F 322	1.R9 receives medications individually with proper flushes in between. 2. R9 is the only resident that receives medication via a G-Tube. 3. G-tube feeding policy and procedure reviewed and revised as necessary. Licensed staff educated to updated policy and procedure. 4. DON or designee will conduct daily audits for 1 week or until all nurses have been observed. Findings will be reported to QAA for recommendation & review.	

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into a plastic medication cup and 30 ml of warm water were added to the cup creating a cocktail of the crushed tablet medications. LPN-A entered R9's room, donned gloves and retrieved a graduated pitcher of water and a 60 ml syringe. LPN-A stopped R9's tube feeding, exposed the resident's G-tube, applied the 60 ml syringe to 1 of the 3 ports in the G-tube, and pulled back on the plunger to check for residual tube feeding. LPN-A then aspirated the mixture of potassium chloride and Prevacid into the syringe, aspirated approximately 50 mls of water into the syringe with the potassium and Prevacid mixture and administered the mixed medication to R9 via port 1 of the G-tube by pressing the plunger of the syringe. LPN-A then aspirated the other crushed medication cocktail into the syringe, added an additional 15 mls of water to the medication cup, aspirated it into the syringe, removed air from the syringe by pressing the plunger and attached the syringe to port 3 of the G-tube and administered the medication cocktail by pressing the plunger. Next, LPN-A drew 60 ml of water into the syringe and administered via port 3 of the G-tube by pressing the plunger. Then she drew 35 ml of water into the syringe and flushed port 2 of the G-tube. She then reattached R9's tube feeding, removed her gloves, and applied hand sanitizer. R9's Physician orders dated 5/30/14, indicated "May crush/dissolve all medications and give per feeding tube." The order did not direct mixing medications or include specific fluid amounts for mixing with medications or flushing the tubing.

During interview on 6/25/14, at 12:48 p.m. LPN-A stated she had worked for the facility for 10 years and has always given medications via G-tube by cocktailing them together. LPN-A stated she had never had any training to give medications

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F 322	Continued From page 71 individually with a flush between medications and was not aware that was a recommended practice. On 6/25/14, at 12:53 p.m. director of nursing (DON) stated she was not aware G-tube medications were to be given individually with flushes between each medication. DON stated the facility had always cocktailed (mixed) medications and given them together. The facility Gastrostomy Feeding Tube Maintenance policy dated 10/2009, directed staff to flush tube with a minimum of 30 ml or the amount ordered by the physician before and after medication or feeding administration, or at least every shift if running continuous. The policy did not address giving medications individually with flushes between medications.	F 322		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	F 353		8/6/14

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F 353	Continued From page 72 Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide sufficient, qualified nursing staff who were available to meet resident daily needs which promoted each resident's physical, mental, and psychosocial well-being, to enhance their quality of life. This had the potential to affect all 26 residents who were currently residing in the facility Findings Include: Refer to F241 as the facility failed to provide timely assistance with toileting, which promoted dignity for 1 of 1 resident (R30), who reported they did not receive timely assistance with their call light request. Refer to F311 as the facility failed to provide assistance with ambulation services for 2 of 3 residents (R21, R20) who required assistance with ambulation. In addition, the facility failed to provide range of motion (ROM) services for 2 of 3 residents (R20, R18) reviewed for ROM. Refer to F314 as the facility failed to ensure a resident identified at risk for pressure ulcers received timely repositioning as assessed to prevent the development of pressure ulcers for 1 of 3 resident (R19) in the sample identified at risk for pressure ulcers.	F 353	1.Refer to 241, R30, Refer to 311 R21, R20, R18; Refer to 314, R19; Refer to 318; R18, R5. 2. Director of Nursing has reviewed staffing to ensure adequate staff is available to meet resident daily needs which promotes each resident's physical, mental, and psychosocial well-being to enhance their quality of life. Nurse in charge of shift will audit to assure care delivery has been provided to all residents. DON or designee will review findings daily to ensure substantial compliance and report findings to the QAA Committee for recommendations and/or comments.	

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F 353	Continued From page 73 Refer to F318 as the facility failed to provide range of motion services as assessed to prevent further decrease in range of motion (ROM) for 2 of 3 residents (R18, R5), in the sample who had limitations in range of motion and were assessed to be assisted with ROM services. During interview on 6/23/14, at 3:55 p.m. R13 stated her blood sugar was low that morning with a reading of 56. R13 stated she had put her call light on to request some orange juice, but stated she ended up going to the kitchen to get it herself when staff did not answer her call light request timely. R13 stated sometimes there was only one aide on duty and she felt the facility needed more staff available to assist residents with cares. R13 stated weekends there seemed to be more problems with lack of staffing. On 6/23/14, at 4:05 p.m. R19 stated the facility does not have enough staff to assist residents with cares. She stated there have been times when there was only one nursing assistant available to care for all 26 residents in the facility. On 6/23/14, at 4:25 p.m. R30 stated staff often turned off his call light and told him they were busy and would come back later to assist him. R30 stated he had waited up to an hour for assistance in the past and had transferred himself back to bed when he had waited too long and couldn't wait any longer. R30 stated, "I know I'm not supposed to do that [transfer without assistance]." On 6/23/14, at 5:52 p.m. R12's family member (F)-A stated she had concerns about the lack of staffing at the facility and felt there wasn't enough staff available to provide timely assistance to	F 353		

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meet residents' needs. F-A arrived at the facility between 7:00 a.m. and 7:30 a.m. each day and assisted R12 with cares until approximately 7:30 p.m. to 8:00 p.m. each evening, as well as volunteered at the facility. F-A stated she provided oral cares, feeding assistance, and also washed R12's face, back, groin, and feet each day. F-A stated she had purchased a reclining wheelchair for R12 because the resident was not promptly put to bed, which at times could be up to an hour wait, and the wheelchair allowed him to rest while waiting for assistance. F-A stated on Friday, 5/23/14, R12 did not receive his scheduled bath due to lack of staffing. She reported R12 received his scheduled Friday evening bath on 5/16/14 and had not received another bath until Tuesday, 5/27/14. F-A brought up concerns regarding R12 not receiving the scheduled bath, and was told by registered nurse (RN)-A there were no staff available to provide R12's bath. F-A stated R12 was also not given a bath as scheduled on Friday, 6/13/14, due to staff shortage and had instead received his bath on 6/14/14. F-A stated R12 had never gone to bed without bathing while living at home and it upset her R12 had not received his baths as scheduled.

On 6/23/14, at 7:00 p.m. R16 stated the facility had difficulty with staff not showing up to work. She stated, "They are working so hard."

On 6/24/14, at 8:35 a.m. F-C stated the facility was, "Running quite short staffed." F-C stated there were only two staff members on duty at night and weekends the facility seemed short staffed, also. F-C stated there had been times she could not find a staff member throughout the entire facility after searching up and down the hallways multiple times. F-C stated R2 had

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waited 1/2 hour or longer for assistance until R2 would give up waiting and just did things on her own. F-C also stated the facility was not walking R2 as they should.

On 6/24/13, at 8:46 a.m. R29 stated he did not feel the facility had enough staff available and stated, "I think they [facility] just squeak by."

On 6/24/14, at 9:23 a.m. R32 stated residents did not consistently receive their range of motion programs because, "The girls [NA] don't come to work." She stated she felt the nurses were doing the best they could, but the facility doesn't have enough staff to provide the necessary cares for the residents.

During an interview on 6/24/14, at 1:49 p.m. F-B stated her main concern regarding the facility was the lack of staffing. F-B stated staff was not providing good perineal care after a bowel movement, and R30 was getting sore. F-B stated there had been staff turnover which had affected care and she was concerned staff weren't getting the proper training to provide adequate care to the residents.

During a follow up interview on 6/24/14, at 2:00 p.m. R30 stated last month, after supper on the evening shift, he put his call light for assistance to urinate. He stated the call light was turned off twice by staff without assistance being provided. R30 stated he had to urinate in his pants waiting for staff and it was "disgusting." R30 stated he transferred himself back to bed although he knew he shouldn't transfer without staff assistance. R30 further stated he was supposed to receive ROM exercises to his right hand daily but he was only receiving it approximately three times per

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F 353	Continued From page 76 week. During interview on 6/24/14, at 3:50 p.m. a staff member, who wished to remain anonymous, stated he/she was concerned about staffing. He/she stated they worked short over half of the time due to open positions, sick calls, and staff not showing up for work. He/she stated this was mostly on the p.m. shift where normal [full] staffing was supposed to be three aides. He/she stated in the past there were evenings with only one aid working to provide cares to all 26 residents in the facility. He/she stated the residents' ROM programs did not always get completed due to staffing issues and residents were not toileted and/ or turned or repositioned in a timely manner. He/she stated staff needed to take shortcuts to get the work done and he/she was concerned about the quality of resident care related to bedsores (pressure ulcers). He/she stated they, "Tried to get to everyone, but sometimes could not get to them [residents] on time." On 6/25/14, at 6:32 a.m. licensed practical nurse (LPN)-B who worked the night shift, stated on nights she was the only nurse and worked with only one nursing assistant (NA) to provide resident cares. LPN-B stated between 11:00 p.m. and 3:00 a.m. they could answer call resident call lights timely. However, around 4:00 a.m., more residents would use their call lights and between the two staff, they could not answer them timely. LPN-B stated there was not enough help after 4:00 a.m. because she needed to pass medications and do LPN tasks prior to 6:00 a.m. LPN-B stated there would often be a resident trying to get up every 10 minutes, and then other call lights would be going off, and there was not	F 353		

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enough staff to provide the necessary cares to the residents.

LPN-B stated the facility was "short staffed" a lot, and at times felt the staffing levels were unsafe [related to providing necessary cares to residents]. LPN-B stated staff do not always come to work when they are scheduled and on the weekends there are only two NAs scheduled to work, and there should be three. LPN-B stated that morning R28 put his call light on when she was in providing cares to another resident. LPN-B stated she answered his call light and told him she would be back in about 10 minutes to apply his leg wraps. LPN-B stated she was not able to get back to R28 for about an hour because she was answering other call lights. LPN-B stated she was frustrated because the facility continued to admit more residents and stated,"We can't handle what we have." LPN-B stated staff can not give baths, make beds, and keep an eye on residents. LPN-B stated she had asked the director of nursing (DON) for the last 3 months for another NA on the night shift and was told by the DON that she was, "Trying."

On 6/25/14, at 9:30 a.m. nursing assistant (NA)-C stated the facility usually had three nursing assistants on the day shift, but would occasionally have two if someone called in sick.

On 6/25/14, at 12:00 p.m. NA-C stated the staff did not have enough time to complete ROM for residents as assessed by the therapists related to the lack of staffing.

On 6/25/14, at 12:05 p.m. family member (FM)-B approached the survey staff and stated, "That is a friggen joke," as he pointed to the administrator

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pushing a meal cart down the hallway. He stated he visited the facility twice a day and at no time had he observed the administrator assisting with the meals. He stated, "All of those extra people in the dining room is a pure joke. They are never here, since you [the survey staff] are in the building, they are all out of the wood work."

On 6/26/14, at 9:00 a.m. RN-A stated the NA staff were scheduled over the Memorial Day weekend (5/24/14-5/26/14), however, staff did not show up for work and there were no replacements. She stated they called everyone to try to fill the shortage but there was no one to call. RN-A stated she worked from 6:00 a.m. to 10:00 a.m. the following day on the medication cart and as the RN in the building, then worked 10:00 a.m. to 2:00 p.m. on the floor [as a nursing assistant] and did the RN work. She stated she went home at 2:30 p.m. and came back in at 4:00 p.m. and worked until 10:30 p.m. She stated she did this for three days. RN-A confirmed they were unable to give R12 his bath over the weekend due to staff shortage. RN-A stated it was a common occurrence to work with staff shortage. She stated according to staffing, there should have been 3 NAs on the day shift, 3 NAs on the evening shift and 1 NA on the night shift. RN-A stated the NAs were getting the work done, however, they may have felt they were not doing as good a job with their duties such as ROM.

On 6/26/14, at 11:55 p.m. NA-G, who had worked at the facility for over a year on the day shift, stated the facility had NA staff but they weren't reliable and would call in sick or not show up for work. NA-G stated this happened, "Too often," but would not say how often it occurred. NA-G stated when this happened; the staff chipped in to

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pick up the slack and was able to get their work done because everyone worked to get it done. She stated she would come in early or stay late occasionally to help when this occurred.

On 6/26/14, at 1:59 p.m. licensed practical nurse (LPN)-C stated they did have difficulty with staffing. She indicated things went well when they had three NAs on staff for days, however, it was only recently that had even been an option. LPN-C stated they are frequently working with two staff and that it was particularly difficult after meal times when residents put call lights on and staff could not leave the dining room.

On 6/26/14, at 2:00 p.m. LPN-D stated from 6/16/14 through 6/22/14 she had been putting at least 2-3 residents to bed each night due to short staffing. She stated the staff is most likely rushing to get work done and resident call lights got turned off and residents were self transferring. LPN-D indicated recently, R5 had reported to her that her call light was turned off and R5 was crying because no one would help her. LPN-D stated R5 had transferred herself while waiting for assistance.

On 6/26/14, at 2:13 p.m. NA-A stated the facility was short of nursing staff. He stated there was usually 2 nursing assistants on the day shift and the evening shift. NA-A stated the first weekend in June 2014, he had arrived to work an evening shift and he was the only NA working. He stated eventually there was an additional staff member who came in but for, "A while" it was just him and a nurse available to provide cares to all 26 residents. He stated this was very difficult weekend, but he felt he could usually complete the tasks assigned to him if there was adequate

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F 353	Continued From page 80 staff available. On 6/27/14, at 11:45 a.m. DON was interviewed regarding the facility's staffing pattern for nursing staff. DON stated her preferred staffing model was as follows: -6:00 a.m. to 2:30 p.m. - 1 RN -6:00 a.m. to 2:30 p.m. - 1 LPN -6:00 a.m. to 2:30 p.m. - 3 NAs -2:00 p.m. to 10:30 p.m. - 1 LPN -2:00 p.m. to 10:30 p.m. - 2 NA -4:00 p.m. to 8:30 p.m. - 1 NA -10:00 p.m. to 6:30 a.m. - 1 LPN -10:30 p.m. to 7:00 a.m. - 1 NA DON stated this is the usual staff schedule she uses when she had available staff. DON stated she would schedule only two NAs from 6:00 a.m. to 2:30 p.m., and 2 NAs from 2:00 p.m. to 10:30 p.m., but that was not what she preferred. She stated scheduling 2 NA during those shifts was "bare bones." On 6/27/14, at 1:34 p.m. the nursing assistant schedules and times sheets were reviewed with DON from 5/12/14, through 6/26/14, and identified the following: The day shift schedule for 5/12/14, through 5/25/14, identified 14 days of which 4 days were scheduled according to the full staff model the DON preferred to use, 7 days (5/17, 5/18, 5/19, 5/22, 5/23, 5/24, 5/25) nursing staff had shortages of one staff member for the entire shift, and 3 days (5/13, 5/15, 5/21) nursing staff had shortages of one staff member for part of a shift. The evening shift schedule for 5/12/14, through 5/25/14, identified 14 days of which 4 days were scheduled according to the full staff model the	F 353		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 81 DON preferred to use, and 10 days (5/12, 5/13, 5/14, 5/15, 5/19, 5/20, 5/22, 5/23, 5/24, 5/25) nursing staff had shortages of one or two staff members for all or part of a shift. The day shift schedule for 5/26/14, through 6/8/14, identified 14 days of which 1 was without shortage, and 13 days (5/26, 5/27, 5/28, 5/30, 5/31, 6/1, 6/2, 6/3, 6/5, 6/6, 6/7, 6/8) nursing staff had shortages of one staff member's. The evening shift schedule for 5/26/14, through 6/8/14, identified 14 days of which 1 day was without shortage, and 13 days (5/26, 5/27, 5/28, 5/30, 5/31, 6/1, 6/2, 6/3, 6/4, 6/5, 6/6, 6/8) nursing staff had shortages of one staff member. The day shift schedule for 6/9/14, through 6/22/14, identified 14 days of which none were without shortage, and all 14 days (6/9, 6/10, 6/11, 6/12, 6/13, 6/14, 6/15, 6/16, 6/17, 6/18, 6/19, 6/20, 6/21, 6/22) nursing staff had shortages of at least one staff member(s). The evening shift schedule for 6/9/14, through 6/22/14, identified 14 days of which 5 were without shortage, and 9 day's, (6/9, 6/14, 6/15, 6/16, 6/18, 6/19, 6/20, 6/21, 6/22) nursing staff had shortage of one staff member. The day shift schedule for 6/23/14, through 6/26/14, identified 4 days of which 1 day (6/23), nursing staff had shortages of one staff member. DON stated staffing had not been at the preferred level from 5/12/14 through 6/23/14 and she had only been able to schedule at the "bare bones" level. DON confirmed she would have staffed at the preferred level, however, there were no staff available to schedule. DON stated she was just recently able to staff at the preferred level on a consistent basis beginning 6/23/14.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		8/6/14

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	245592	A. BUILDING _____ B. WING _____	06/27/2014

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F 356	Continued From page 82 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility to ensure the required daily nurse staff posting included the actual hours worked by each category of nursing staff. This had the potential to affect all 26 resident's	F 356	1.Director of Nursing has updated Posted Nursing Hours Form. 2. Review and revise Posted Nursing staff policy. 3. DON or Designee will Audit daily x7 days moving to 1x a week x4 weeks. Findings	

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F 356	Continued From page 83 currently residing in the facility, family members, and any visitors who may have chosen to view this information. Findings include: During observation on 6/23/14, at 1:40 p.m. the nurse staff posting was posted on the wall next to the nurse's station. The posting consisted of a laminated piece of paper which identified the date, the current resident census, and the number of registered nurse (RN), licensed practical nurses (LPN), and nursing assistants (NA). The posting indicated the number of employees of each category and a column wish indicated "hours." The information on the form had been documented with a dry erase marker. The posting did not indicate the actual shift hours worked by each discipline. Additional observations of the nurse staff posting on 6/24/14, at 9:00 a.m. and on 6/25/14, at 7:05 a.m. revealed the same posting format on the laminated sheet. The post continued to lack the identification of the actual shift hours worked by each discipline. During interview on 6/25/14, at 11:45 a.m. the director of nurses (DON) stated the facility had been utilizing the laminated sheet for the daily staff posting for several years. She stated the staff member's write the numbers for staffing on the laminated sheet daily with a dry erase marker. She stated the facility kept track of the daily hours on a facility form titled Report of Nursing Staff Directly Responsible for Resident Care. The DON stated the day and the night shifts worked full 8 hour shifts, however, the evening shift worked a half shift from 4-8:30 p.m. The DON	F 356	will be reported to QAA for recommendation & review.	

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F 356	Continued From page 84 confirmed the staff posting did not identify the half shifts. Review of the Report of Nursing Staff Directly Responsible for Resident Care identified the date, the resident census, the shift, RN, LPN, and NA's. The total number of staff and the total hours were identified, but the form did not include the actual shift hours worked by each nursing discipline. On 6/26/14, at 9:00 a.m. the DON stated the facility did not have a policy regarding the staff posting.	F 356		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents received physician visits every 60 days for 1 of 3 residents (R21) reviewed for physician visit timeframe's. In addition, the facility failed to ensure physician visits were completed every thirty days, for the first 90 days, for 2 of 3 newly admitted residents (R16, R3), who were reviewed for timely physician required visits.	F 387	1.R21, R16 and R3 have had physician visits. 2. All residents□ records have been audited to assure timely physician visits. 3. Administrator has reviewed physician visit requirements with SSD. Facility Physician visit policy and procedure has been reviewed and updated. 4. Social Services Designee will audit to ensure compliance monthly x3	8/6/14

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F 387	Continued From page 85 Findings include: R21's physician visits were reviewed and the resident had received a physician's visit on 1/21/13, 1/28/13, 11/16/13, and 3/12/14. During interview on 6/27/14, at 11:44 a.m. the social service designee (SSD) stated she was responsible for scheduling the residents for their 60 day physician visits. The SSD stated she thought when R21 had audiology (the study of hearing disorders) appointments she could count them as 60 day physician visits. The SSD verified the physician 60 day visits were lacking and had not been completed timely for R21. R16's Admission Face Sheet indicated R16 was admitted to the facility on 2/20/14, with diagnoses including hypercholesterolemia, and status post acute venous embolism. The clinical record indicated R16 was evaluated by a physician on 3/10/14 and 6/16/14. The clinical record did not include physician visits every thirty days for the first 90 days. During interview on 6/26/14, at 3:40 p.m. the director of nursing (DON) reviewed R16's record and confirmed R16 had not received a physicians visit every 30 days for the first 90 days of admission to the facility. During interview on 6/26/14, at 3:50 p.m. the SSD stated she scheduled the physician visits for the facility. She stated she had difficulty keeping track of the visits because some of the physicians do not come to the facility on a regular schedule. SSD stated she was aware R16's primary physician did not come to the facility for routine visits, but confirmed she had not made alternative	F 387	and quarterly thereafter. Findings will be reported to QAA for recommendation & review.	

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F 387	Continued From page 86 arrangements to ensure R16 had received every 30 days visits for the first 90 days after admission. R3's admission Minimum Data Set (MDS) dated 3/13/14, indicated R3 was admitted to the facility on 3/7/14 with diagnoses including atrial fibrillation, heart failure, hypertension, and dementia. The clinical record indicated R3 was evaluated by a physician on 4/24/14, and 6/15/14. The clinical record did not include physician visits every thirty days for the first 90 days. On 6/26/14, at 3:44 p.m. nursing consultant (NC) confirmed the resident did not have a 30 day physician visit. NC stated the physician did not keep his scheduled visit day in May and the person coordinating the physician visit's was not informed of the cancellation. The General Policies dated 4/2014, indicated residents were to be seen every 30 days by a physician for the first 90 days of placement.	F 387		
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews	F 497		8/6/14

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F 497	Continued From page 87 and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide annual evaluations and the required 12 hours of in-service training per year for 3 of 3 nursing assistants, (NA-G, NA-I, NA-J) reviewed that have worked in the facility for greater than 12 months. Findings include: NA-G was hired on 1/7/13. Her personnel file was lacking an annual performance review. In addition, NA-G was lacking the required 12 hours of in-service training per year. NA-I was hired on 1/7/13. Her personnel file was lacking an annual performance review. In addition, NA-I was lacking the required 12 hours of in-service training per year. NA-J was hired on 9/12/11. Her personnel file was lacking an annual performance review. In addition, NA-J was lacking the required 12 hours of in-service training per year. During interview on 6/27/14, at 8:44 a.m. the director of nursing (DON) stated she was behind on doing performance reviews. The DON verified NA-G, NA-I and NA-J had not received a performance review since hired. The DON stated new employees get about 6 hours of training on	F 497	1.Policy and Procedure has been implemented to provide all nursing assistants with a minimum of 12 hours of educational opportunities. 2. Policy and Procedure has been reviewed and revised to assure each nursing staff receives annual evaluations. 3. DON or designee will complete nursing staff evaluations yearly upon anniversary date to ensure compliance. DON or designee will audit all nursing assistant records to determine educational needs. The educational opportunity calendar will be reviewed to assure all staff stays current on mandatory monthly trainings. All nursing assistant training records would be audited annually. Educational Findings will be reported to QAA for recommendation & review.	

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F 497	Continued From page 88 their first day of orientation. The DON stated the training included items that were not resident centered training i.e. employee benefits, disciplinary action, and union contract issues. The DON stated other training the employees received were provided with videos, however, the DON had not timed the videos to know how long they actually were. The DON verified the three NA's were lacking the required 12 hours of training. The facility General Policies revised 11/11, indicated annual evaluations were held with each employee. The In-service Education policy revised 9/07, indicated NA's were required to receive 12 hours of continuing education per year.	F 497		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to train employees upon hire regarding the facility's emergency procedures for 3 of 3 newly hired nursing assistants (NA)-F, NA-G, NA-I), 1 of 1 newly hired licensed practical nurse (LPN)-B and 1 of 1 newly hired dietary aides (DA)-A reviewed during the extended survey. This had the potential to effect all 26 resident's currently residing in the facility.	F 518	1.Policy and Procedure for Emergency Preparedness has been reviewed and revised. 2. All facility employees shall receive emergency preparedness update in-service. Upon hire and/or yearly all staff will be educated of Emergency Preparedness procedure. Findings will be reported to QAA for recommendation & review.	8/6/14

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F 518	Continued From page 89 Findings include: NA-F was hired on 5/1/14, and her personnel file was lacking emergency procedure training. NA-G was hired on 1/7/13, and her personnel file was lacking emergency procedure training. NA-I was hired on 1/7/13, and her personnel file was lacking emergency procedure training. LPN-B was hired on 12/19/13, and her personnel file was lacking emergency procedure training. DA-A was hired on 5/13/14, and her personnel file was lacking emergency procedure training. During interview on 6/27/14, at 8:44 a.m. the director of nursing (DON) stated employees watched a training DVD regarding fire safety and also reviewed the facility's policies on disaster preparedness. However, the DON confirmed the above identified staff had not received the required training since hired. During interview on 6/27/14, at 10:28 a.m. DA-A stated she had not received fire training, however, DA-A stated she had watched the fire video, and then asked maintenance staff where the pull stations and extinguishers were located since she was working in the kitchen. DA-A stated the maintenance staff told her where the items were located in the facility. The facility Fire Training policy dated 10/84, indicated each employee would be instructed about the different types of fire extinguishers and their uses. Each employee would open the fire extinguisher cabinet door and lift the extinguisher out, and would be shown how to pull the pin, hold the hose toward the base of the flame, and shoot the extinguisher. Each employee would be shown	F 518		

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F 518	Continued From page 90 where each extinguisher was, where each alarm was, the procedure to follow, and when to sound the alarm In the kitchen, the employee would be shown the CO2 dry chemical fire extinguishing system, learn how the system worked, and would be shown the use of the fire blanket.	F 518		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		8/6/14

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F 520	Continued From page 91 Based on interview and document review, the facility did not ensure the quality assurance committee identified facility quality concerns and developed/ implement policies and systems to ensure quality of life and quality of care for 26 of 26 residents residing in the facility. Findings include: Refer to F241 as the facility failed to provide timely assistance with toileting to promote dignity for 1 of 1 resident, (R30) was not provided timely assistance with toileting. Refer to F242 as the facility failed to provide 2 of 3 residents (R16, R19) choices about baths and schedules according to previous life routines. Refer to F244 as the facility failed to act upon resident grievances for 2 of 3 residents, (R19, R16) who had a grievance in regards to not receiving the rehabilitation program as assessed. Refer to F311 as the facility failed to provide assistance with ambulation services for 2 of 3 resident's (R21, R20) who were assessed as requiring assistance with ambulation. In addition, the facility failed to provide range of motion (ROM) services for 2 of 3 residents (R20, R18) reviewed for ROM. Refer to F314 as the facility failed to ensure 1 of 3 resident's (R19), identified at risk for pressure ulcers, received the necessary care and treatment as assessed to prevent the development of pressure ulcers.	F 520	1.Quality Assurance members have been educated to the responsibility of discussing and implementing an action plan as it relates to the resident care. All staff has been educated to the role of the Quality Assurance Committee and the method to bring forth comments/concerns. The Quality Assurance Sub- Committee met and has reviewed or updated Quality Assurance action plans and goals. Quality Assurance will review and provide comment for action plans and goals for regular scheduled meetings.	

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F 520	Continued From page 92 Refer to F318 as the facility failed to provide range of motion services as assessed to prevent further decrease in range of motion for 2 of 3 resident's (R5, R18), who had limitations in range of motion. Refer to F497 as the facility failed to provide annual evaluation's and the required 12 hours of in-service training per year for 3 of 3 nursing assistants (NA-G, NA-I, NA-J), who have worked in the facility for greater than 12 months. Refer to F518 as the facility failed to ensure training was provided on the facility's emergency training for 3 of 3 newly hired nursing assistants (NA-F, NA-G, NA-I), and 1 of 1 newly hired licensed practical nurse (LPN)-B, and 1 of 1 newly hired dietary aides (DA)-A. During interview on 6/27/14, at 10:15 a.m. the Administrator and Director of Nursing (DON) verified the identified areas of concern found at the facility had been identified by staff, however, were not addressed at the the Quality Assurance Committee (QA) meetings and stated they had not been a part of the Quality Assurance process. On 6/27/14, at 11:13 a.m. the administrator stated, "We do not have an effective QA program at this time." The administrator also stated as of next month he would be taking over the Quality Assurance program and will work on putting a program into place to address problems and concerns and "Develop a better program." A facility policy titled, Quality Assurance and Assessment Committee Policy, revised 6/2010, indicated, The Quality Assurance Committee	F 520		

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F 520	Continued From page 93 identifies and addresses quality issues and implements corrective action plans as necessary. During another interview on 6/27/14, at 11:58 a.m. the DON verified that the facility QA policy was followed.	F 520		

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

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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, State Fire Marshal Division. 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	K 000	POC ok JB 7-25-14 RECEIVED JUL 25 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 8-6-14
EXIT: 6-27-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 7/25/14

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 _____	06/25/2014

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency 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
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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 26 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 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. This deficient practice could affect residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 3:00 PM and 5:30 PM on 06/25/2014, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Director (BD) revealed the that the facility failed to conduct and document 5 of 12 monthly 30 second tests and the annual 90 minute test for the battery back up lighting within the last 12 months.	K 046	The battery for the backup emergency lighting system was replaced and tested on 6/26/14. The Director of Maintenance will test and document monthly a 30 second test and an annual 90 minute test. Findings will be reported to QAA for recommendations & review. Date Completed: 6/26/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 046	Continued From page 3 These deficient practices were confirmed by the Maintenance Director (BD).	K 046		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
July 15, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5592023

Dear Mr. Ahlf:

The above facility was surveyed on June 23, 2014 through June 27, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697