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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KFE9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00449

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **9/21/2017** (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 **35** (L18)
13.Total Certified Beds **35** (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
	35			
(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 :
Lyla Burkman, Unit Supervisor 09/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 10/13/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/14/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245592 September 26, 2017

Ms. Laura Erickson, Administrator
Oakland Park Communities
123 Baken Street
Thief River Falls, MN 56701

Dear Ms. Erickson:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective September 12, 2017 the above facility is certified for or recommended for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 26, 2017

Ms. Laura Erickson, Administrator
Oakland Park Communities
123 Baken Street
Thief River Falls, MN 56701

RE: Project Number S5592026

Dear Ms. Erickson:

On August 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 3, 2017. 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 September 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 20, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 3, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 3, 2017, effective September 12, 2017 and therefore remedies outlined in our letter to you dated August 11, 2017, will not be imposed.

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.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KFE9

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Facility ID: 00449

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(L2) **852108000**

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(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 **08/03/2017** (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) :

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NEII 08/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/14/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2017

Ms. Laura Erickson, Administrator
Oakland Park Communities
123 Baken Street
Thief River Falls, MN 56701

RE: Project Number S5592026

Dear Ms. Erickson:

On August 3, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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 electronically delivered CMS-2567, whereby corrections are required.

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;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
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 September 12, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 12, 2017 the following remedy will be imposed:

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

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 November 3, 2017 (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 February 3, 2018 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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 _____	08/03/2017

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 On 7/31/17- 8/3/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable 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.	F 000		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		9/12/17

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

Electronically Signed | 08/15/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	08/03/2017

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 323	Continued From page 1 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure side rails were safe and functional for 2 of 2 residents (R30 and R3) who required the use of side rails. Findings include: R30's significant change Minimum Data Set (MDS) dated 7/27/17, indicated R3 was diagnosed with chronic heart failure and a stroke. The MDS also indicated R30 had intact cognition and required extensive assistance with bed mobility and transfers. R30's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 7/29/17, indicated R30 required assistance with bed mobility and transfers. R30's Physician Order Report dated 7/9/17, included an order for a 1/2 side rail to the outside of the bed to increase safety and independence with bed mobility.	F 323	Bed rails for R30 and R3 were replaced on 8/3/2017 with secure rails in good repair. All resident bed side rails will be assessed for safety and functionality by 9/12/17. The Assist Rails policy and procedure was updated to have the nurse assess the bed side rail for safety and functionality of the rail once bed side rail is installed. The Side Rail Assessment and Consent observation in the electronic health record was updated to include an area to assess for safety and functionality of side rail. Director of Nursing or designee will audit side rail assessments 1x/month x6 months to ensure safety and functionality of side rails is addressed. Side rails will be assessed for sturdiness and repair on a quarterly basis by the Maintenance Director or designee. Administrator or designee will audit maintenance records on a quarterly basis x6 months. Results will be presented to the QAA committee on a quarterly basis.	

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 _____	08/03/2017

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 323	Continued From page 2 R30's Progress Note dated 6/13/17, indicated R30 required the use of a 1/2 rail for bed mobility and transfers. The note did not address the safety or functionality of the rail. R30's Care Plan dated 6/13/17, indicated R30 utilized a 1/2 side rail on the bed to increase independence and safety with transfer in and out of bed and for repositioning while in bed. On 8/1/17, at 3:10 p.m. R30's side rail was observed raised, bent and leaning towards the mattress at an approximate 30 degree angle. The rail was securely affixed to the bed frame, however, the rail wiggled approximately 3-4 inches back and forth creating a potential entrapment area. On 8/2/17, at 1:20 p.m. R30 stated she utilized the rail daily to get in and out of bed and it wiggled when she used it. -At 1:22 p.m. registered nurse (RN)-A confirmed R30 utilized her side rail to aide in bed mobility. RN-A was observed to wiggle the rail and confirmed the rail was bent and was not secure. RN-A stated the rail could be replaced. RN-A reviewed R30's side rail assessment/progress note dated 6/13/17, and stated the assessment addressed R30's need for the rail, however, it did not address the functionality and/or safety of the rail. - At 2:20 p.m. the director of environmental services stated he had replaced R30's side rail on	F 323		

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	245592	A. BUILDING _____ B. WING _____	08/03/2017

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F 323	Continued From page 3 7/31/17. He stated the rail itself was affixed securely to the bed however, the metal bed frame was weak and moved back and forth when the rail was utilized. He confirmed the rail moved, creating a potential entrapment hazard. R3's annual MDS dated 3/22/17, indicated R3 had diagnoses including arthritis and dementia. The MDS also indicated R3 had cognitive impairment and required limited assistance of one for bed mobility and extensive assistance of one for transfers. R3's ADL CAA dated 3/22/17, indicated R3 required extensive assist with all transfers. R3's Physician Order Report dated 6/13/17, included an order for a half side rail to the outside of the bed to increase safety and independence with transfers in and out of bed and with repositioning once in bed. A Progress Note dated 6/13/17, indicated R3 appropriately utilized a 1/2 side rail to the outside of bed to increase independence with transfer and bed mobility. The note did not address the safety or functionality of the rail. R3's Care Plan dated 6/13/17, indicated R3 required the use of a 1/2 side rail on the outside of the bed to assist with repositioning and transfers.	F 323		

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F 323	Continued From page 4 On 8/1/17, at 3:10 p.m. R3's side rail was observed to wiggle 3-4 inches from the mattress creating an entrapment hazard. On 8/2/17, at 1:22 p.m. R3 stated the rail wiggled but she liked to use it when transferring in and out of bed at night. - At 1:25 p.m. RN-A confirmed the rail was loose and could be replaced with a stronger option. RN-A confirmed the side rail assessment/ progress note dated 6/13/17, identified R3's need for the rail, however, did not address the safely or functionality of the rail. On 8/3/17, at 9:17 a.m. the director of nurses (DON) stated she had completed the side rail assessments to ensure the residents required continued use of the rail, however, confirmed the assessments did not address the safety or functionality of the rail. The undated Assist Rails policy directed the facility staff to assess the resident to ensure they required the continued use of the rail, however, the policy did not direct the staff to ensure the safety and functionality of the rail.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		9/12/17

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F 329	Continued From page 5 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician had documented the justification for the continued use of mood altering medications for 1 of 5 residents (R35) who utilized mood altering	F 329	R35's current medication regime was discussed with her primary care provider during her routine nursing home visit on 8/5/17. R35's physician stated that the resident should be seen and followed by	

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F 329	Continued From page 6 medications. Findings include: R35's Annual Minimum Data Set (MDS) dated 4/5/17, indicated R35's diagnoses included anxiety, manic depressive disorder, and bi-polar disorder. The MDS also indicated R35 had intact cognition, had not displayed mood or behavior problems during the assessment period, and received antidepressant and antianxiety medications daily. R35's Psychotropic Medication Care Area Assessment (CAA) dated 4/8/17, indicated R35 utilized psychotropic medication to manage the signs and symptoms of bipolar disease and depression. R35's Physician's Order Report dated 2/4/17, indicated R35 was to receive fluvoxamine (a benzodiazepine) 150 milligrams at bedtime. The fluvoxamine was started on 5/2/16. The report also indicated R35 was to receive clonazepam (a benzodiazepine) 1 mg daily at bedtime. The clonazepam order had been started on 12/10/16. R35's Care Plan dated 4/23/17, identified R35 as having episodes of increased anxiety as exhibited by rapid, unintelligible speech, multiple request to stay in bed or recliner, refusals to come out of her room for meals or activities, visible shaking, trembling of hands, and fearful or anxious facial	F 329	psych despite family's reluctance; the first available appointment was scheduled for October 19th. All residents will continue to have monthly review of medications by consulting pharmacist. Residents receiving psychotropic medications will continue to have medications by and effectiveness reviewed at least quarterly per facility Psychotropic Medication Policy. A document has been developed and will be implemented by date certain to better facilitate communication with physicians specifically regarding residents receiving psychotropic medications. The nurse will prepare the document and it will be provided to the physician at least quarterly to ensure the correct documentation is in place to justify continued use of medications and/or to ensure appropriate and timely dose reductions. Psychotropic medications will continue to be tracked and reviewed according to our current policy and procedure. Audits will be completed by DON or designee at least monthly for 3 months to ensure proper use of newly implemented documentation form during quarterly review process. Results of audits will be brought to QAA for presentation and discussion to ensure compliance.	

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F 329	Continued From page 7 expression. The plan directed the staff to administer the medications as ordered and monitor for effectiveness. Throughout the survey conducted on 7/31/17, 8/1/17, 8/2/17 and 8/3/17, R35 was observed to interact with other residents, staff and visitors without difficulty. At no time, was R35 observed to display adverse behaviors. A Consultant Pharmacist Medication Review dated 10/19/16, indicated the pharmacist had identified R35 had received the same dose of fluvoxamine without a trial reduction. The primary physician replied on 11/11/16, and indicated R35 had suffered from depression all of her life and any medication changes were to be approved by the psychiatrist. R35's Physician Progress Note identified the following information: -6/26/16, R35's bipolar disorder was "currently followed by psychiatry." -2/4/17, R35's bipolar disorder was "followed by psychiatry." -4/27/17, indicated R35's bipolar disorder was followed by psychiatry R35's medical record lacked any type of psychiatry progress notes/orders. R35's medical record also lacked identification of the justification for the continued use of the medications.	F 329		

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F 329	Continued From page 8 Review of R35's Nursing Progress Notes revealed the following: -7/29/17, at 11:55 a.m. R35 had increased anxiety, refused to allow staff to assist her with cares. -7/27/17, at 3:14 p.m. R35 was found sitting on the edge of her bed ringing her hands together, grinding her teeth, panic look in her eyes, stated she did not feel good . -7/18/17, at 8:47 p.m. R35 refused to eat or to use the restroom during the evening shift. On 8/2/17, at 1:52 p.m. registered nurse (RN)-A stated R35 had displayed behaviors, she was unpredictable and had a life long history of depression and bipolar disorder. RN-A stated R35 had seen psychologists in the past for medication adjustments, however, her primary psychologist had left the area. RN-A stated she had conversations with R35's family members regarding continued psychiatric care, however, the family had refused the only local psychiatric provider therefore R35 was not currently under the care of a psychiatric provider. RN-A stated she would have the medications reviewed by her primary physician on 8/5/17, during routine rounds. On 8/3/17, at 9:22 a.m. the director of nurses confirmed R35 was not currently receiving psychiatric care as the family had refused the local provider therefore R35's medications had not been reviewed for continued use. The DON confirmed R35's medical record lacked justification for the continued use of medications.	F 329		

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F 329	Continued From page 9 The Psychotropic Medication policy dated 3/18/16, indicated the facility would work with the physicians and mid level providers to ensure appropriate use of the psychotropic medications. The facility was to ensure the residents receiving the medications were adequately monitored and had adequate indications for all psychotropic medications.	F 329		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced	F 371		9/12/17

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F 371	Continued From page 10 by: Based on observation, interview and document review, the facility failed to ensure kitchen cabinets were maintained in a clean and sanitary condition which had the potential to affect all 32 residents who received food from the kitchen Findings include: On 8/1/17, at 2:54 p.m. an environmental tour of the kitchen was completed with the dietary manager (DM) the following was observed: -Four orange cabinets above a food preparation counter were observed to have a black, sticky substance on the cabinet faces. Covered cinamon rolls were placed on the counter below the cabinets. -Four cabinets above the food puree counter were observed to have a grimy, sticky substance on the cabinet faces. Food puree and blenders were on the counter below the cabinets. The puree and blender equipment were not covered and their lids were not in place. At the time of the observation, the DM confirmed the cabinets were not clean and stated staff had tried to clean the cabinets, however, it resulted in removing paint around the cabinet handles. The DM stated they were unable to remove the sticky substances from the cabinets thereore the cabinets were not cleanable. The DM stated debris could stick to surface of the cabinets and potentially fall into food items being prepped on counters below the cabinets which was a potential risk for a food borne illness.	F 371	The four cabinets above the food preparation counter and the four cabinets above the food puree counter will be cleaned and painted to ensure ability to clean the cabinets. The Dietary Manager or designee will complete a monthly sanitation audit of the kitchen. Any sanitation concerns will be addressed immediately, and if needed, a maintenance request will be submitted to the maintenance department. Results of the sanitation audits will be presented at QAA on a quarterly basis.	

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F 371	Continued From page 11 The facility dietary department policy dated 6/91, indicated sanitary conditions are maintained in the storage, preparation, and distribution of food. Equipment must be kept in good condition.	F 371		
F 441 SS=C	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441		9/12/17

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F 441	Continued From page 12 to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to develop and implement a program to reduce the risk of a Legionella (a bacterium) in the facility water system to prevent cases and outbreaks of Legionnaires' disease (a serious type of	F 441	A program to reduce risk of Legionella will be developed and implemented by the Administrator and Maintenance Director. The program will be implemented upon development and followed. Results of the	

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F 441	Continued From page 13 pneumonia). This had the potential to affect all 32 residents who resided in the facility. Findings include: During interview on 8/1/17, at 9:30 a.m. the administrator stated she was unaware of Legionella, the infection related to the organism or the requirements that the facility should have in place. The administrator stated she would check with maintenance and infection control policies to see if the facility had anything in place. During interview on 8/1/17, at 9:58 a.m. the facility administrator confirmed she was not aware of the CMS [Centers for Medicare & Medicaid] requirements regarding Legionnaires' Disease. The facility administrator verified the facility had not started a facility risk assessment or policy and procedure development.	F 441	program will be presented to QAA on a quarterly basis.	
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.	F 465		9/12/17

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F 465	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean, sanitary and safe carpeted flooring in the common area and the Paradise wing. This had the potential to affect all residents, staff and visitors to the areas. Findings include: Throughout the survey on 7/31/17, 8/1/17, 8/2/17, and 8/3/17, the common area and Paradise wing carpet was observed to have black stained areas and unclean. In addition, the Paradise wing carpet was observed to have numerous wrinkles which could be potential tripping hazards. On 8/1/27, at 11:13 a.m. R36 stated the carpet in the common area and Paradise wing did not look clean. On 8/2/17, at 12:57 p.m. family member (FM)-A was oberseved walking in the Paradise hall. FM-A stated the carpeting was dirty and in need of cleaning and proceeded to step down on a raised wrinkle in the carpeting and stated it was a tripping hazard. On 8/2/17, at 11:53 a.m. an environmental tour of the facility was conducted with the director of environmental services (DES) and the administrator. The administrator confirmed the carpeting of the common area and Paradise wing	F 465	The carpet down Paradise wing and in the common area was cleaned on 8/8/2017. Quotes for replacing the carpet down Paradise wing have been requested; the carpet will be replaced as soon as the vendor is able. Environmental safety issues will be reported by any/all staff members to the Maintenance Director as soon as an issue is noticed. The Maintenance Director will address the issue as soon as possible, and if further resources are needed, the issue will be reported to the Administrator. Major maintenance repairs and projects will be reported to QAA.	

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F 465	Continued From page 15 were not clean and the Paradise wing carpet had numerous raised wrinkles. -At 12:00 p.m. the DES confirmed the Paradise wing was approximately eight feet wide and the last 40 feet contained 20 plus wrinkles with a height of 1/2 inch to 1 1/2 inches. The wrinkles ranged in width from six inches to four feet across areas of the hallway. The DES confirmed the wrinkles could potentially be tripping hazards. The DES stated the carpet was cleaned 5/30/17, however, confirmed the carpeting was not clean. - At 12:05 p.m. the administrator stated they had the Paradise carpeting repaired on two separate occasions, however, the wrinkles came back. The administrator stated the areas just bubbled up and they were not sure why. The administrator confirmed the carpets were unclean and the carpet on the Paradise wing was a potential tripping hazard. The facility Maintenance Service Policy, revised 8/17, indicated maintenance service would be provided to all areas of the building, grounds, and equipment and the building would be maintained in good repair and free from hazards.	F 465		

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	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, 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 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Healthcare Facilities Code. 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	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/15/2017

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 _____	**08/01/2017**

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K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@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. The facility has a fire alarm system with smoke detection at the smoke barriers for door release, in corridors and in common areas that are open to the corridor. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire

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K 000	Continued From page 2 alarm system. The facility has a capacity of 35 beds and had a census of 31 at the time of the survey The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to keep exits free of obstructions as stated in the Life Safety Code (NFPA 101) 2012 edition sections 19.2.7 & 7.1.10. This deficient practice could restrict the exiting during an emergency and affect 19 of the 31 residents and an undetermined amount of staff and visitors. Findings Include: During the facility tour, at 10:50 am on 8/1/2017 observations revealed a baseball sized hole in the side walk along the path of travel of the exit discharge in the sunshine wing This deficient condition was confirmed by the Maintenance Supervisor.	K 271	The hole in the sidewalk next to the exit on Sunshine wing was repaired on 8/2/2017 by the Maintenance Director. The Maintenance Director or designee will complete quarterly audits of the emergency exits to ensure they are free of obstructions.	8/2/17
K 324	NFPA 101 Cooking Facilities	K 324		8/15/17

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K 324 SS=D	Continued From page 3 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide supervision of the cooking equipment as stated in the Life Safety Code (NFPA 101) 2012 edition section 19.3.2.5.3. This deficient practice could, if turned on by accident allow for minor injury to a resident or cause a fire which could affect an undetermined amount of residents, staff and visitors. Findings include:	K 324	Breakers for stove in Gathering Room were turned to "off" position by the Administrator on 8/1/17. Notice was placed on the stove stating, "The breakers for the stove/oven must be turned off immediately after use. The stove/oven may not be left unattended while the breakers are on." An audit will be conducted on a weekly basis x3 weeks and monthly x3 months by the Maintenance Director, Administrator, or	

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K 324	Continued From page 4 During the facility tour at 10:05 am on 8/1/2017 observations revealed the cook stove in the gathering room was unattended and not locked out. This deficient condition was confirmed by the Maintenance Supervisor.	K 324	his/her designee to ensure that the breakers are off.	
K 346 SS=F	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period as per NFPA 101 2012 edition section 9.6.1.6. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 31 residents as well as an undetermined number of staff, and visitors to the facility Findings include: At 9:32 am on 8/1/2017 record review revealed the Fire Alarm Out of Service policy did not contain the proper procedures and did not have the current contact information.	K 346	The "Fire Protection Systems: Out of Service" policy and procedure has been revised on 8/8/2017 to reflect current regulations. Policy states the authority having jurisdiction shall be notified if the fire alarm system is out of service for more than 4 hours in a 24 hour period, and the building will be evacuated or an approved fire watch will be provided until the alarm systems are returned to service. Fire Marshal contact information was updated. The Maintenance Director is responsible for making needed changes to the policy and procedure in the future.	9/12/17

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K 346	Continued From page 5 This deficient condition was confirmed by the Maintenance Supervisor.	K 346		
K 354 SS=F	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for ten or more hours in a 24 hour period as per NFPA 25. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 31 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: At 9:32 am on 8/1/2017 record review revealed the Fire Sprinkler Out of Service policy did not	K 354	The "Fire Protection Systems: Out of Service" policy and procedure has been revised 8/8/2017 to reflect current regulations. Policy states the Fire Chief shall be notified immediately if the sprinkler system is out of service, and the State Fire Marshal shall be notified if the sprinkler system is out of service for more than 10 hours in a 24 hour period; the building or affected part of the building will be evacuated or an approved fire watch will be provided until the sprinkler system is returned to service. Fire Marshal contact information was updated. The Maintenance Director is responsible for making needed changes to the policy and procedure in the future.	9/12/17

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K 354	Continued From page 6 contain the proper procedures and did not have the current contact information. This deficient condition was confirmed by the Maintenance Supervisor.	K 354		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 31 residents and an undetermined amount of staff and visitors. Findings include: At 9:15 am on 8/1/2017 record review revealed there was no documentation of a fire drill being conducted on the 2nd shift in the 2nd quarter.	K 712	Fire drills will be conducted on each shift on a quarterly basis at unexpected times and under varying conditions starting immediately. Fire drill dates and times will be audited by the Administrator or designee on a monthly basis x6 months.	9/12/17

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K 712	Continued From page 7 This deficient condition was confirmed by the Maintenance Supervisor.	K 712		