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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OLFB

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 **09/14/2015** (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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 09/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/24/2015 (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
09/11/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245592

November 24, 2015

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 .

Effective September 1, 2015 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
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 17, 2015

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

RE: Project Number S5592024

Dear Ms.. Erickson:

On August 3, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 23, 2015. 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 14, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 28, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 23, 2015, effective September 1, 2015 and therefore remedies outlined in our letter to you dated August 3, 2015, 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 related to this eNotice.

Sincerely,

Mark Meath

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

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	9/14/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	**09/01/2015**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	**09/01/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**09/01/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	**09/01/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**09/01/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	**09/01/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	**09/01/2015**	ID Prefix **F0361** Reg. # **483.35(a)** LSC	**09/01/2015**	ID Prefix **F0363** Reg. # **483.35(c)** LSC	**09/01/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	**09/01/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**09/01/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**09/01/2015**
ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	**09/01/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**09/01/2015**	ID Prefix Reg. # LSC	Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	09/17/2015	28035	09/14/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/23/2015

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 **01 - MAIN BUILDING 01**	8/28/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **07/24/2015**	ID Prefix	Correction Completed **08/07/2015**	ID Prefix	Correction Completed **07/24/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0018		LSC K0025	
ID Prefix	Correction Completed **07/24/2015**	ID Prefix	Correction Completed **07/24/2015**	ID Prefix	Correction Completed **07/24/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0047		LSC K0054	
ID Prefix	Correction Completed **08/19/2015**	ID Prefix	Correction Completed **07/29/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0076		LSC K0147		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/21/2015	_____	**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: OLFB

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

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/23/2015** (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 :
Theresa Gullingsrud, HFE NEII — 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/10/2015 (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

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
August 3, 2015

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

RE: Project Number S5592024

Dear Mr. Ahlf:

On July 23, 2015, 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 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;

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 1, 2015, 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 1, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 October 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of

payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2016 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	07/23/2015

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.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		9/1/15

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

Electronically Signed | 08/12/2015

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.

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	245592	A. BUILDING _____ B. WING _____	07/23/2015

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

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a uniform denial letter upon termination of all Medicare Part A skilled services for 5 of 5 residents (R26, R24, R27, R14, R9) reviewed for liability notice and beneficiary appeal rights review. Findings include: R26 was discharged from Medicare Part A on 4/20/15, and remained in the facility until she expired on 4/20/15. The facility did not provide R26 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid	F 156	1.R26 & R24 Have expired. R9 has been discharged. R14 & R27 have been given denial letters from recent Medicare coverage. 2. All residents currently on a Medicare Skilled service are reviewed weekly to determine progress in their status. 3. Upon review, should a resident be determined to no longer qualify for a skilled service, the Business Office Manager shall initiate a SNFABN as appropriate. The current policy & procedure regarding SNFABN was reviewed and revised as needed by the Clinical Team August 25, 2015. 4. Within 48 hours of the weekly Medicare Meeting, the Administrator will review the record to determine the appropriate notice	

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F 156	Continued From page 3 Services (CMS)-10055 or a uniform denial letter to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R24 was discharged from Medicare Part A on 2/9/15, and remained in the facility until he expired on 5/8/15. The facility did not provide R24 and/or his legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 or a uniform denial letter to inform him of potential liability for non-covered services and of his right to appeal the denial to Medicare. R27 was discharged from Medicare Part A on 2/4/15, and was a current resident of the facility. The facility did not provide R27 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 or a uniform denial letter to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R14 was discharged from Medicare Part A on 6/5/15, and was a current resident of the facility. The facility did not provide R14 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 or a uniform denial letter to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R9 was discharged from Medicare Part A on 2/9/15, and remained in the facility until she was discharged on 2/9/15. The facility did not provide R9 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 or a uniform denial letter	F 156	was given. Outcome audits shall be presented to the QAA Committee for review & comment.	

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F 156	Continued From page 4 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. On 07/22/15, at 2:24 p.m. the business office manager (BOM) stated she only provided the Notice of Medicare Provider Non-coverage form for Medicare beneficiaries whose services were ending. The BOM confirmed she had not provided R26, R24, R27, R14 or R9 the SNFABN or one of the five uniform denial letters. On 07/23/2015, at 3:31 p.m. the administrator verified the SNFABN or uniform denial letter should have been provided to R26, R24, R27, R14 and R9 as required. A policy regarding liability notices and beneficiary appeal rights was requested but none was provided.	F 156		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164		9/1/15

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F 164	Continued From page 5 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide privacy during insulin administration for 2 of 5 residents (R20, R22) observed to receive an insulin injection in a public place. Findings include: R20 received the midday insulin injection in a public area with others in close proximity. R20's Diagnosis Sheet dated 12/31/13, identified R20's diagnoses to include diabetes mellitus, chronic kidney failure, dementia, cerebral vascular accident (stroke) with right sided weakness and aphasia (language disorder that affects a person's ability to communicate). R20's quarterly Minimum Data Set (MDS) dated 5/22/15, indicated R20's cognition was intact, however, R20's speech was unclear and she usually could make herself understood. In addition, R20 received daily insulin injections.	F 164	1. & 2. All residents that receive blood sugar monitoring and/or insulin injections shall be provided total privacy while receiving those interventions as well as receive blood sugar monitoring prior to eating meals. 3. All nurses will be educated on the appropriate locations within the Center to provide therapeutic interventions on August 19, 2015. The current policy & procedure was reviewed and revised as needed. 4. The DON or designee shall complete observational audits on all nurses, weekly X 2 weeks who provide diabetic interventions to assure ongoing compliance. All audit outcomes shall be presented to the QAA Committee for review & comment.	

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F 164	Continued From page 6 R20's Care Area Assessment (CAA) summary dated 2/10/15, indicated secondary to R20's stroke she had significant dysarthria (difficult or unclear articulation of speech), which made R20 difficult to understand. R20's Physician's Orders and Progress Notes dated 2/8/15, directed staff to administer an injection of four units of Novolog insulin at the midday meal. On 7/21/15, at 11:44 a.m. licensed practical nurse (LPN)-A was observed to move R20 in her wheelchair approximately one foot into the nursing station area. R20's wheelchair faced the medication cart with her back towards the common area. LPN-A used a gloved hand lifted R20's shirt, exposed a portion of R20's abdomen and administered R20's insulin injection. At this time, the director of nursing (DON) was seated at the nursing station and eight residents were seated in the common area. R22 received the midday insulin injection in a public area with others in close proximity. R22's Diagnosis Sheet dated 8/20/13, identified R22's diagnoses to include dementia and diabetes mellitus. R22's quarterly MDS dated 4/21/15, indicated R22 had severe cognitive impairment and received daily insulin injections. R22's Physician's Orders and Progress Notes dated 7/10/15, directed staff to administer an injection of four units of Humalog insulin before	F 164		

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meals and blood sugar checks twice a day.

On 7/21/15, at 11:47 a.m. LPN-A was observed to move R22 in her wheelchair into the nursing station area. R22 was positioned with the back of her wheelchair on the edge of the nursing station area. R22's back was towards the common area and she was facing the medication cart. LPN-A used a gloved hand, lifted R22's shirt, exposed a portion of R22's abdomen and administered R22's insulin injection. At this time, the DON was seated at the nursing station and eight residents were seated in the common area.

The nursing station was an open area with a low countertop that when one was seated at the station one could visualize the main common area. The main common area was an open area which residents, family and visitors were observed to congregate. This was the only nursing station in the facility and throughout the time on survey, visitors, family and others were observed to approach the nursing station and congregate in the common area.

On 7/21/15, at 1:50 p.m. LPN-A stated it was common practice to administer resident's insulin injections at the nursing station. LPN-A stated she thought if she positioned the resident with their back towards the outside and only lifted their clothing up a little bit it was okay.

On 7/21/15, at 1:57 p.m. the DON confirmed insulin injections should be administered in the most private setting possible. The DON stated she had questioned LPN-A of why she had not taken the residents into the DON office which was located adjacent to the nursing station. The DON confirmed the open nursing station was a public

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F 164	Continued From page 8 setting. Administration of Subcutaneous Injections policy dated 7/2015, directed staff to ensure resident privacy and dignity when administered injections and blood glucose checks.	F 164		
F 225 SS=D	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 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	F 225		9/1/15

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F 225	Continued From page 9 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 serious injuries of unknown origin immediately to the state agency (SA) for 1 of 4 residents (R27) reviewed for accidents and 1 of 5 incident reports reviewed. Findings include: The facility's Abuse Prevention Plan dated July 2015, directed staff that initial reports of abuse must be reported to the SA immediately without delay via the SA's secure web site. R27's significant change Minimum Data Set dated 5/14/15, indicated R27 was diagnosed with anemia, hypertension, diabetes and osteoporosis. The MDS also indicated R27 had moderate cognitive impairment and required extensive assist of one staff for transfers, dressing, toilet use and locomotion on and off the unit. The MDS further indicated R27 required extensive assistance with ambulation and had two or more falls since admission. Review of the Nurses' Notes and Accident/Incident Report dated 2/28/15, at 7:40 a.m. indicated R27 was found on the floor in her room with a laceration to the back of her head. R27 was taken to the emergency room where she	F 225	1. Incidents dated 3/18/15 & 2/28/15 for R27 have been submitted to the SA for review. 2. All resident incidents are communicated to the Administrator immediately for initial review & screening of a potential report to the SA. Incidents meeting regulations defining vulnerable adult issues will be reported to SA immediately by Administrator, DON, or supervising nurse. 3. The Center's policy & procedure for reporting vulnerable adult issues has been reviewed and has been updated to reflect the procedure for who is required to report the incident to the SA immediately; additionally the policy was updated to report only to MDH, and no longer CEP. All supervisory staff have been educated on notifying the SA according to policy guidelines and updated submission information by September 1, 2015. 4. All reviewed data shall be submitted to the QAA Committee for comment &/or review.	

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F 225	Continued From page 10 received 7 staples to the back of her head. The administrator was notified of the incident at 8:25 a.m. however, the state agency was not notified of the incident. Review of the Nurses' Notes and Accident/Incident Report dated 3/18/15, at 3:35 p.m. indicated R27 was found face down on the floor in her room. She had a bump on the left side of her forehead and was bleeding. R27 was taken via ambulance to the emergency room where she was diagnosed with a fracture of her left maxillary sinus. The administrator was notified of the incident on 3/18/15. However, the SA was not notified of the incident until 3/19/15. On 7/23/15, at 2:48 p.m. the director of nursing (DON) verified the SA was not notified of the injury on 2/28/15, and the injury on 3/18/15, was not reported to the SA until 3/19/15, the next day. On 7/23/15, at 3:05 p.m. the administrator confirmed the injuries should have been reported to the SA immediately as directed in their policy.	F 225		
F 226 SS=D	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 implement their Abuse Prevention	F 226	1. Incidents dated 3/18/15 & 2/28/15 for R27 have been submitted to the SA for	9/1/15

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F 226	Continued From page 11 Plan policy and procedure related to immediately reporting to the state agency (SA) injuries of unknown origin for 1 of 4 residents (R27) reviewed for accidents. Findings include: The facility's Abuse Prevention Plan dated July 2015, directed staff that initial reports of abuse must be reported to the SA immediately without delay via the SA's secure web site. R27's significant change Minimum Data Set dated 5/14/15, indicated R27 was diagnosed with anemia, hypertension, diabetes and osteoporosis. The MDS also indicated R27 had moderate cognitive impairment and required extensive assist of one staff for transfers, dressing, toilet use and locomotion on and off the unit. The MDS further indicated R27 required extensive assistance with ambulation and had two or more falls since admission. Review of the Nurses' Notes and Accident/Incident Report dated 2/28/15, at 7:40 a.m. indicated R27 was found on the floor in her room with a laceration to the back of her head. R27 was taken to the emergency room where she received 7 staples to the back of her head. The administrator was notified of the incident at 8:25 a.m. however, the state agency was not notified of the incident. Review of the Nurses' Notes and Accident/Incident Report dated 3/18/15, at 3:35 p.m. indicated R27 was found face down on the floor in her room. She had a bump on the left side of her forehead and was bleeding. R27 was taken via ambulance to the emergency room	F 226	review. 2. All resident incidents are communicated to the Administrator immediately for initial review & screening of a potential report to the SA. Incidents meeting regulations defining vulnerable adult issues will be reported to SA immediately by Administrator, DON, or supervising nurse. 3. The Center's policy & procedure for reporting vulnerable adult issues has been reviewed and has been updated to reflect the procedure for who is required to report the incident to the SA immediately; additionally the policy was updated to report only to MDH, and no longer CEP. All supervisory staff have been educated on notifying the SA according to policy guidelines and updated submission information by September 1, 2015. 4. All reviewed data shall be submitted to the QAA Committee for comment &/or review.	

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F 226	Continued From page 12 where she was diagnosed with a fracture of her left maxillary sinus. The administrator was notified of the incident on 3/18/15. However, the SA was not notified of the incident until 3/19/15. On 7/23/15, at 2:48 p.m. the director of nursing (DON) verified the SA was not notified of the fall on 2/28/15, and the fall on 3/18/15, was not reported to the SA until 3/19/15, the next day. On 7/23/15, at 3:05 p.m. the administrator confirmed the falls should have been reported to the SA immediately as directed in their policy.	F 226		
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. 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).	F 279		9/1/15

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F 279	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review the facility failed to develop care planning interventions related to diabetic management for 2 of 5 residents (R20, R22) who were insulin dependent diabetics. Findings include: R20's care plan lacked diabetic management interventions. R20's Diagnosis Sheet dated 12/31/13, identified R20's diagnoses to include diabetes mellitus (DM), chronic kidney failure, dementia, cerebral vascular accident (stroke) with right sided weakness and aphasia (language disorder that affects a person's ability to communicate). R20's quarterly Minimum Data Set (MDS) dated 5/22/15, indicated R20 received daily insulin injections. R20's Physician's Orders and Progress Notes dated 2/8/15, directed staff to: · Conduct blood glucose checks twice a day · Administer 4 units of Novolog insulin at midday meal · Administer 12 units of Lantus insulin at bedtime R20's care plan printed 7/23/15, at 1:00 p.m. failed to identify R20's DM diagnosis and corresponding interventions which could have directed staff to observe for signs and symptoms of hyperglycemia (high blood sugar levels), hypoglycemia (low blood sugar levels), nail and skin care etc.	F 279	1. R20 & R22¿s care plans have been reviewed & revised to reflect their current issues related to their diabetic needs with MD notification criteria included. 2. All resident¿s requiring diabetic monitoring have had their care plans reviewed & revised as needed to reflect current status. The policies & procedures for diabetic management including the tracking, timing & documentation of obtaining blood sugars, food & fluid intake related to blood sugar readings have been reviewed & revised as needed. 3. & 4. All staff caring for diabetic residents have been educated on monitoring/recording diabetic resident¿s status as well as MD notification criteria on August 19, 2015. The DON or designee shall review all resident care plans with a diagnosis of Diabetes to assure compliance initially or as needed, but at least quarterly. Additionally, the DON or designee shall do observational audits daily X5 days; weekly X 2 weeks and then randomly every month X 3 mos. or until 100% compliance is confirmed with blood sugar draws, documentation of same, intake patterns related to BS readings and MD notification as may be needed. All review outcomes shall be presented to the QAA Committee for comment & review.	

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F 279	Continued From page 14 On 7/23/15, at 10:48 a.m. the director of nursing (DON) confirmed R20 was an insulin dependent diabetic and the care plan care plan lacked a focus area and interventions regarding diabetes management. The DON stated it would have been appropriate to include interventions such as observe for signs and symptoms of bruising at injection sites, diet restrictions, hyperglycemic reactions, hypoglycemic reactions, notification to physician with changes and monitoring blood sugars and insulin therapy as directed by the physician. R22 had diabetes and the care plan lacked diabetic management interventions. R22's physician orders dated 7/10/15, indicated a diagnosis of diabetes and subsequent orders for blood sugar checks twice a day in the morning and evening and Humalog insulin injection four units three times a day before meals. R22's care plan dated 7/21/15, indicated R22 had blood sugar checks and insulin injections daily. However, the care plan failed to identify corresponding interventions and directives to monitor for signs and symptoms of hyperglycemia, hypoglycemia, nail and skin care precautions etc. On 7/23/15, at 2:16 p.m. the DON reviewed R22's care plan and confirmed the plan did not direct staff how to care for R22's diabetic monitoring and care needs. Nursing Care Plans policy dated 7/2015,	F 279		

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F 279	Continued From page 15 indicated resident care plans would be detailed, individualized and updated with changes as needed.	F 279		
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 perform accurate blood sugar monitoring and maintain accurate documentation of blood sugar results in order to ensure appropriate medical management for 1 of 5 residents (R22) reviewed and identified as insulin dependent diabetics and had not received adequate monitoring. Findings include: R22's quarterly Minimum Data Set (MDS) dated 4/21/15, indicated R22 had severe cognitive impairment and required extensive assist with all activities of daily living (ADLs). R22's physician orders dated 7/10/15, indicated diagnosis of diabetes (DM) with subsequent orders for blood sugar checks twice a day in the morning and evening and Humalog insulin injection of four units three times a day before	F 309	1. R22¿s record has been reviewed and presented to the MD for review & comment. 2. All resident¿s requiring diabetic monitoring have had their care plans reviewed & revised as needed to reflect current status. The policies & procedures for diabetic management including the tracking, timing & documentation of obtaining blood sugars, food & fluid intake related to blood sugar readings have been reviewed & revised as needed. 3. & 4. All staff caring for diabetic residents have been educated on monitoring/recording diabetic resident¿s status as well as MD notification criteria on August 19, 2015. The DON or designee shall review all resident care plans with a diagnosis of Diabetes to assure compliance initially or as needed, but at least quarterly. Additionally, the	9/1/15

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F 309	Continued From page 16 meals. R22's care plan dated 7/21/15, indicated R22 had blood sugar checks and insulin injections daily. However, the plan failed to identify interventions and directives related to diabetic nail and skin care and monitoring and / or care for the symptoms of hyperglycemia (high blood sugar levels), hypoglycemia (low blood sugar levels. On 7/22/15, at 8:58 a.m. after R22 had finished the breakfast meal, licensed practical nurse (LPN)-A was observed to wheel R22 out of the dining room. LPN-A wheeled R22 into a small corridor next to the dining room. LPN-A proceeded to perform R22's blood sugar check. LPN-A informed R22 the blood sugar result was 298, and then administered R22's insulin into R22's abdomen. Following the injection, LPN-A documented R22's blood sugar reading in R22's medication administration record (MAR). However, LPN-A failed to indicate in the record that R22 had just consumed the breakfast meal which could have resulted in the elevated blood sugar reading. (The American Diabetes Association suggests normal blood sugar levels before a meal (fasting) to be less than 80-130 and less than 180 1-2 hours after beginning the meal). On 7/22/15, at 9:00 a.m. LPN-A stated resident blood sugar checks / glucose monitoring was to be completed before meals to ensure an accurate fasting reading. However, LPN-A stated R22 had been served breakfast prior to having her blood sugar checked and she did not want to remove R22 from the dining room once she had been served the meal. LPN-A stated staff usually had R22 wait at the nurses station to ensure she had	F 309	DON or designee shall do observational audits daily X5 days; weekly X 2 weeks and then randomly every month X 3 mos. or until 100% compliance is confirmed with blood sugar draws, documentation of same, intake patterns related to BS readings and MD notification as may be needed. All review outcomes shall be presented to the QAA Committee for comment & review.	

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received her blood sugar monitoring prior to breakfast but she was running late today and R22 had already eaten breakfast.

R22's clinical record included a facsimile communication dated 4/3/15, in which the facility informed R22's primary physician that R22's morning blood glucose levels were fluctuating and the facility requested an order to increase R22's glucose monitoring to twice a day. R22's primary physician responded on 4/6/15, and directed staff to monitor R22's glucose levels twice per day. R22's record lacked any further follow up documentation and / or evaluation of R22's glucose results.

R22's clinical record indicated R22 was seen by her primary physician on 3/16/15, 4/27/15, and 6/29/15. At no time did the physician progress notes related to the visits indicate concerns related to R22's glucose results.

Review of R22's MAR's revealed the following information:

- March 2015, R22's glucose was identified over 200 on 8 of 31 days. The highest recoding was on 3/23/15, which indicated R22's glucose was 361. Although R22 had several high blood sugar readings, the clinical record lacked documentation related to the high levels and/or communication of the results to the primary physician.

- April 2015, R22's morning glucose was recorded over 200 on 6 of 30 days. The highest recording was on 4/2/15, which indicated 281. Although R22 had several high blood sugar readings, the clinical record lacked

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documentation related to follow up physician review of the elevated blood sugars.

- June 2015, R22's glucose was recorded as over 200 on 8 of 30 days. The highest recording was on 6/26/15. which indicated R22's glucose was 303. Although R22 had several high blood sugar readings, the clinical record lacked documentation, related to the high levels and/or communication of the results to the primary physician.

- July 1-22, 2015, R22's glucose was identified over 200 on 7 of 22 days. The highest recorded glucose was on 7/22/15, which indicated R22's glucose was 298. Although R22 had several high blood sugar readings, the clinical record lacked documentation related to the high levels and/or communication of the results to the primary physician.

R22's clinical record included a hemoglobin A1C lab (a blood draw to test a person's average blood sugar over a three month time span) completed on 10/17/14, with a result of 6.8 %, which indicated as high with a reference range of 4.3 % - 5.7%. R22 had a second A1C completed on 7/1/15, with a result of 7.3%. Although R22's A1C was elevated, which could be indicative of unmanaged blood glucose / diabetes, the facility did not follow up with the physician or ensure the abnormal blood sugars were reviewed by the physician.

On 7/22/2015. at 1:53 p.m. the director of nursing (DON) stated all residents who were on a scheduled dose of insulin should have their blood sugars checked before meals to ensure an accurate reading. The DON stated when a

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F 309	Continued From page 19 residents blood sugar was checked, the nurse did not write what time it was completed, therefore, there was no way to know if the results were obtained before or after the meal. The DON stated if a fasting blood sugar was greater than 200, the nurse should have made a notation in the residents clinical record and also notified the physician. On 7/23/15, at 2:16 p.m., the DON reviewed R22's care plan and confirmed the plan did not direct staff how to care for R22's diabetic needs. The policy entitled Oakland Park Communities Standards of Care and Protocols for Diabetes Management dated 7/2015, indicated that an ideal blood sugar pre-meal range is 80-140 and an acceptable range is 80-160. In addition, the policy instructed nursing staff to review blood glucose results with physician as needed to make appropriate adjustments in insulin and management of diabetes.	F 309		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 334		9/1/15

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F 334	Continued From page 20 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 334		

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F 334	Continued From page 21 the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to confirm pneumococcal vaccination status and administration if indicated for 1 of 5 residents (R7) reviewed for pneumococcal vaccination status. Findings include: R7's Diagnosis Sheet dated 4/30/12, identified R7's diagnoses to include Alzheimer's disease, hypertension (high blood pressure), atrial fibrillation (irregular heart rate), anxiety and failure to thrive. R7's quarterly Minimum Data Set (MDS) dated 5/19/15, indicated R7's pneumococcal vaccination was not up to date and that R7 had not been offered the pneumococcal vaccination. R7's Adult Vaccine Administration Record indicated R7 had been provided the influenza vaccination on 11/24/14, however lacked documentation of when R7 had received the pneumococcal vaccination.	F 334	1. R7¿s record has been reviewed and updated for her pneumococcal status. 2. All new & current resident records have been reviewed for their pneumococcal status. 3. & 4. Pneumococcal policy & protocols have been reviewed and revised as needed. The DON or designee will audit all new admissions for documented pneumococcal status. All pneumococcal audits will be submitted to the QAA Committee for comment & review.	

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F 334	Continued From page 22 R7's Standing Order form dated 5/3/12, directed staff to administer the pneumococcal vaccination if not contraindicated. On 7/21/15, at 10:39 a.m. the director of nursing (DON) confirmed R7's medical record lacked documentation of R7's pneumococcal vaccination history. The DON confirmed R7 should have been offered the pneumococcal vaccination. On 7/23/15, at 11:00 a.m. the DON confirmed R7 had been sent to the clinic and received her pneumococcal vaccination on 7/21/15, after the surveyor had brought this to the facility's attention. In addition, the DON stated they had identified eight other residents (R3, R4, R8, R10, R13, R16, R22, R27) whose pneumococcal vaccination history had not been assessed and whom the pneumococcal vaccination was indicated. Vaccination Administration - Influenza and Pneumococcal policy dated 3/2015, indicated pneumococcal vaccinations were available year round to all residents. Documentation of the pneumococcal vaccination administration should be recorded in the medical record on the Adult Vaccine Administration Record. Pneumococcal Vaccination Pocket Guide dated 12/2009, indicated the pneumococcal vaccination was indicated for persons over the age of 65. In addition, if the history of the vaccination was unknown a reasonable effort would be made to obtain the vaccination history and when in doubt, vaccinate.	F 334		
F 361	483.35(a) QUALIFIED DIETITIAN - DIRECTOR	F 361		9/1/15

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F 361 SS=F	Continued From page 23 OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's registered dietitian (RD) failed to provide guidance and in-service training to the dietary staff. This deficient practice had the potential to affect all 26 residents residing in the facility and received food from the kitchen. Findings include: On 7/22/15, at 12:45 p.m. the dietary manager stated she had started working at the facility on 7/14/15. She stated the previous kitchen manager left the facility the end of May, 2015. On 7/22/15, at 2:30 p.m. the registered dietitian (RD) stated she had been visiting the facility to complete clinical dietary needs. She stated she visited the facility 8 hours a month and as	F 361	1. A Dietary Manager has been hired and the contracted RD is having on-going meetings with the DM, providing consultation for the dietary department operations. 2. The RD will provide written updates to the Administrator after each visit, outlining the topics covered with dietary staff & recommendations made for ongoing dietary department compliance, including any educational sessions. 3. The Administrator will conduct weekly observational audits X 1 month with the Dietary Manager of the Kitchen¿s physical plant to assure ongoing physical plant compliance. 4. All reviews shall be presented to the QAA Committee for comment & review.	

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needed. This included reviewing the resident's assessment, completion of the Minimum Data Set (MDS) and reviewing the resident care plans. She stated Cook-A and Cook-B were in charge of the kitchen and she had not provided any training or guidance to the dietary staff.

On 7/22/15, at 2:45 p.m. Cook-A and Cook-B stated the administrator and the business office manager were in charge of the kitchen. They stated in the absence of a dietary manager, they ensured the food order was completed and that as it. Cook-A stated the facility had utilized cleaning schedules in the past, but the kitchen staff had stopped using them sometime in June 2015.

On 7/22/15, from 3:30 p.m. to 4:00 p.m. the dietary manager was informed of the identified dietary concerns and also verified the facility's failure to ensure the following:
- The facility's failure to ensure meat was thawed appropriately.
- The facility's failure to ensure dietary dishwashing equipment was functioning properly.
- The facility's failure to ensure the walk in freezer was maintained properly.
- The facility's failure to ensure essential equipment including stoves and fry pans were maintained properly.
- The facility's failure to follow the developed menus.
- The facility's failure to provide nutritionally sound meal choices.

Review of the Dietician Consultant Service for Oakland Park Communities dated 4/27/15, indicated the RD had charged the facility for a total of 10 hours worked. The report dated 5/25/15, indicated the RD had charged the facility

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F 361	Continued From page 25 14 hours and the report dated 6/16/15, indicated the RD was in the facility for a total of 24 hours. The reports did not indicate what the RD had completed or had done during her visits to the facility. On 7/23/15, at 1:00 p.m. the intern administrator stated he was in charge of personal issues in the kitchen. He verified from the end of May 2015, until last week (7/14/15), the kitchen staff did not have a dietary director. He verified he did not complete any type of kitchen sanitation reviews in the absence of the dietary manager. He stated the RD came to the facility for 8 hours a month but he did not keep track of when she was there nor did he get a report as to what work she had completed during her visits. A policy related to the RD role in the absence of a dietary director was requested but none was provided.	F 361		
F 363 SS=F	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow menus and serve adequate meal time portion sizes. This had the potential to effect all 26 residents who resided	F 363	1. & 2. All residents will be served portion sizes dependent on their physician ordered diet. Additionally, there will be a posted alternate to the main entrée¿.	9/1/15

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F 363	Continued From page 26 in the facility and received food from the kitchen. Findings include: On 7/22/15, at 8:00 a.m. family member (FM)-A stated the evening meal on 7/21/15, did not have enough meat on the menu. She stated the meal consisted of small amount of turkey with gravy over mashed potatoes. FM-A stated the facility had not served enough food and the residents left the dining room hungry. On 7/22/15, at 11:50 a.m. Cook-A was observed to set up the noon meal in the steam table. The meal consisted of cubed steak and brown gravy, fried potatoes with onions, cream style corn, wheat bread with margarine, ice cream and milk. The steam table was not observed to contain alternative meats or vegetables. The table did have potatoes in two forms: mashed or fried. Review of the menu indicated the facility served regular, pureed, mechanical soft, low salt, consistent carbohydrate, concentrated carbohydrate small and small portion menus. Each of the diet types were to receive three ounces of meat, either a 1/3 or a 1/4 cup of corn and potatoes. At 12:05 p.m. Cook-A began serving the resident meals. She was not observed to use any type of list or review individual resident dietary instructional cards while serving the meal. Cook-A was observed to cut some of the meat portions in half and serve 1/4 cup potatoes and 1/4 cup corn and for other residents she served a full portion of meat and 1/3 cup potatoes and 1/3 cup of corn. Cook-A instructed the nursing assistance as to whom to serve the meals to.	F 363	3. The dietary Manager will audit all records to assure diet orders match serving directions with portion sizes & food types. Thereafter, the Dietary Manager will conduct observational audits on food preparation, serving protocols and portion sizes at 2 meals/day X 1 week. Audits will continue at 2 meals/day, 2X week for 3 weeks or until 100% compliance is achieved. The Administrator will review all dietary audits for comment & review. 4. All reviews shall be presented to the QAA Committee for review & comment.	

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F 363	Continued From page 27 -At 12:13 p.m. Cook-A stated the smaller 1/4 cup scoop and the 1/2 portions of meat were to be given to all of the residents on diabetic diets. She stated the 1/3 cup scoop was to be used for the rest of the residents. She stated the diabetic residents always received a smaller portion. Cook-A stated the facility did not give the residents a choice as to what was to be served. She stated there was one resident who may not like the meal and proceeded to pull out a single portion of pork roast from the meat steam pan. The pork was observed in a plastic Ziploc bag which was tucked into the steam table pan directly touching the other meat portions. She stated she prepared the alternative meat and served it to the one resident who would occasionally ask for something different. She verified the facility did not have alternative meal items prepared for the other residents and they did not offer the alternatives to residents unless they refused the meal. -At 12:20 p.m. Cook-A reviewed the menus and verified each of the diet types included 3 ounces of meat. The starch and the vegetable differed for each diet type, but the protein portion was consistent for each diet. Cook-A stated she was not aware she was to serve full portions of protein to each of the residents. On 7/22/15, at 12:35 p.m. the dietary manager verified the facility was not serving the correct portion sizes to the residents as directed by the menus. She verified the facility dietary staff were in need of training. She stated the facility had alternative menus in the past, but they had stopped preparing the alternatives sometime ago. She stated she would be looking into alternative meal choices for the residents.	F 363		

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F 363	Continued From page 28 On 7/23/15, at 3:40 p.m. R19, an alert and oriented resident, stated the meals were too small. She stated sometimes we were not given "enough to feed a bird." R19 stated the residents were served small portions on a regular basis. The undated Serving Utensil policy directed the staff to read the menu and serve the appropriate portion to the residents using the correct utensil.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain sanitary conditions in the kitchen which had the potential to affect all 26 residents residing in the facility and who were served meals from the kitchen. Findings include: On 7/20/15, at 2:10 p.m. during the initial kitchen tour with Cook-B, the following concerns were identified: - A six inch frying pan sitting on the stovetop was	F 371	1. The 6" frying pan has been discarded. The bakers cupboard have been cleaned and storage containers discarded. All undated opened containers/packages of food have been discarded or labeled with the date opened. The cornbread muffin can was discarded. The sweet cornbread muffin mix was discarded. The can of cocoanut flakes was discarded. Two 24¿ pans were discarded. 2. A Dietary Manager has been hired by	9/1/15

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F 371	Continued From page 29 observed to have a thick layer of black buildup along the inside of the pan where the handle was connected to the pan. - A 12-14 pound turkey breast and thigh roast was observed to be thawing on a cookie sheet on the counter. The roast was still frozen. On 7/20/15, at 2:20 p.m. Cook-B stated the roast was for the next days supper meal. She stated staff usually took the roast out two days before, but since it had not been taken out yet, she had placed the roast on the counter around noon to thaw. She verified the facility practice was to thaw the meat in the refrigerator and not on the counter. Cook-B placed the roast in the refrigerator. - The bakers cupboards were observed to contain several tin cans with lids used as storage containers which were not cleanable. - A can identified as graham cracker crumbs dated 1/30 (no year) was opened. The crumbs were noted to be rancid and the inside of the lid was observed to have rust formations. The dietary manager verified the crumbs would not be safe to use. - A can identified as sweet cornbread muffin mix, did not identify when they had been placed in the can. The outside bottom seal of the can was observed to have rust formations on it. - A can of coconut flakes did not include a date when the flakes were placed into the can. When the dietary manager opened the flakes, they were noted to be yellow in color. The dietary manager stated the flakes were not safe to use.	F 371	the Facility and cleaning schedules have been developed. Dietary staff will be educated on dietary protocols including cleaning schedules, serving protocols, food prep, including thawing of entrée¿ meats and diet control on August 19, 2015. 3. The Dietary Manager will complete observational audits 2X/week X 1 week and weekly thereafter to assure dietary compliance is sustained. 4. All audits will be presented to the quarterly QAA Committee for comment & review.	

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F 371	Continued From page 30 -Two 24 inch skillets and the 6 inch fry pan were all observed to have thick, black debris built up inside of the pans. The dietary manager verified the blackened area did not come off when cleaned, therefore; the pans were uncleanable. On 7/22/15, at 12:45 p.m. the dietary manager stated she had started working at the facility on 7/14/15, and the previous kitchen manager had left the facility at the end of May, 2015. On 7/22/15, at 2:30 p.m. the registered dietitian stated she had visited the facility to complete clinical dietary needs. She stated she had not been in charge of kitchen sanitation. She stated Cook-A and Cook-B were in charge of the kitchen. On 7/22/15, at 2:45 p.m. Cook-A and Cook-B stated the administrator and the business office manager were in charge of the kitchen. They stated in the absence of a dietary manager, they ensured the food order was completed. Cook-A stated facility had utilized cleaning schedules in the past, but the kitchen staff stopped using them sometime in June 2015. On 7/23/15, at 1:00 p.m. the intern administrator stated he had been in charge of personnel issues in the kitchen. He verified he did not complete any type of kitchen sanitation reviews in the absence of the dietary manager. The Cleaning Schedule food service policy dated 5/17/09, directed the dietary staff to maintain the sanitation of the food service department through routine cleaning schedules.	F 371		

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F 371	Continued From page 31 The Food Storage policy dated 5/17/08, directed the staff to thaw meet at 41 degrees F or below. All food that needed to be thawed must be identified with the date to which it was removed from the freezer. The policy also directed staff to ensure open dry goods were stored in tightly sealed labeled and dated containers. The policy further read "Any open products should be placed in seamless plastic containers with tight -fitting lids."	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		9/1/15

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F 431	Continued From page 32 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin pens were properly labeled with the date opened for 1 of 5 residents (R20) who was insulin dependent and utilized insulin adminstration pens. In addition the facility failed to ensure medications were stored properly in the refrigerator for 1 of 5 residents (R22) who utilized insulin pens. This practice had the potential to affect all residents who required medications to be stored in the refrigerator. Findings include: On 7/22/15, at 2:15 p.m. the medication cart was reviewed with licensed practical nurse (LPN)-A. The following insulin pen was observed lacking a "when opened" date: · R20's Novolog insulin pen which had been dispensed on 11/2014 LPN-A verified the above insulin pen was lacked a "when opened" date. On 7/22/15, at 2:30 p.m. the medication refrigerator was observed to contain food	F 431	1. Insulin pens have been labeled and appropriately stored for R20 & R22. 2. All Insulin products are properly stored and dated when opened. 3. All staff who administer insulin or receive medication orders/supplies have been educated on medication storage protocols as well as dating all insulin products when opened. DON or designee will audit insulin products and their storage every week X 4 weeks and then every 2 weeks X 60 days or until 100% compliance is achieved. 4. All audit results shall be presented to the QAA Committee for comment & review.	

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F 431	Continued From page 33 products and nutritional supplements on the top two shelves. On the third shelf there was an opened box of Novolog insulin pens labeled for R22. The box had four Novolog insulin pens left in the box (box when full held eight insulin pens). Food was observed to have dripped on the opened box of Novolog insulin pens. The director of nursing (DON) and LPN-A confirmed the food had dripped onto R22's box of Novolog insulin pens, which was not appropriate. In addition, the DON confirmed insulin pens should have been labeled with a "when opened" date.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		9/1/15

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F 441	Continued From page 34 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an ongoing, comprehensive infection control surveillance program related to the tracking and trending of infections. This had the potential to effect all 26 residents who resided in the facility. Findings include: On 7/23/15, at 11:00 a.m. director of nursing (DON) confirmed she coordinated the infection control program. Reviewed with the DON the facility's Organism Nosocomial Infection Report logs (January 2015 - June 2015) which had the following information: · Month and year of review · Resident name · Resident room number · Date of onset · Symptoms · Infection site · Culture (yes/no) · Organism	F 441	1. & 2. All confirmed resident infections and as well as resident¿s with potential infections shall be monitored with the data being tracked and trended for symptoms, treatment, location, type and overall prevalence and potential sources on a retrospective as well as concurrent basis. 3. Policies & procedures have been reviewed and revised as needed. Daily, the DON or designee shall review shift reports for reported changes in a resident¿s status. Should infection symptoms be noted, the DON or designee will initiate additional monitoring or interventions to alleviate the symptoms. Should the symptoms progress, MD notification shall be initiated for further review. This data shall be entered on a flow sheet for continued monitoring and/or resolution information. Individual resident infections/symptomology progress will be documented in the resident record. Summary data will be collected on a	

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F 441	Continued From page 35 · Treatment · Effective (yes/no) · Precautions (yes/no) The DON confirmed the data for the current month (July 2015) was not recorded yet. The DON stated her process for identifying infections was at the end of each month she reviewed the medication administration record (MAR) of each resident and if a resident was placed on an antibiotic or treatment that would have indicated an infection she would add the resident information to the list. The DON would then conduct a medical record review and gather the rest of the information to complete the log. The DON confirmed she had not been conducting an ongoing, concurrent review of infection control concerns. In addition, the DON verified she had not been conducting symptomology tracking/trending of residents who had symptoms but who were not placed on an antibiotic. On 7/23/15, at 1:36 p.m. the DON stated she conducted random surveillance observations on staff, however, she was unable to provide any results, analysis or plans for improvement from this surveillance activity. The Management of Outbreak of Communicable Disease policy [undated] indicated the infection control coordinator would be responsible for receiving surveillance information, tabulating the data and maintaining a line listing of identified cases. The Outbreak Surveillance for Infections/Infectious Diseases policy [undated] directed the infection control coordinator to	F 441	concurrent data collection sheet will be collated for analysis at least quarterly. 4. Analyzed data will be presented to the QAA Committee for comment & review.	

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F 441	Continued From page 36 collect, tabulate surveillance data to remain aware of trends and an increase in prevalence of infectious conditions. The Process Surveillance policy [undated] indicated process surveillance would be completed to help identify whether practices complied with established prevention and infection control procedures and policies. In addition, the process surveillance would be completed using audit forms.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain safe, sanitary and functional equipment in the kitchen. This had the potential to affect 26 of 26 residents who received food from the kitchen. Findings include: On 7/20/15, at 2:10 p.m. the initial tour of the kitchen was completed with Cook-B and the following concerns were identified: - The walk in freezer was observed to have condensation ice build up hanging from the ceiling above the fan. The ice formations on the ceiling were approximately 1/2 inch in diameter and were scattered on the ceiling a 12 inch radius	F 456	1. Condensation has been removed from the walk-in freezer. The water leaks from the dishwasher has been repaired and lime build-up removed. Water leaks from the dishwasher handle have been repaired. 2. Policies and procedures related to maintenance have been reviewed and revised as needed. Staff were educated on reporting maintenance issue protocols. 3. The Dietary Manager will perform weekly audits on all dietary equipment, monitoring for function & cleanliness. Audits will be given to the Administer for review. 4. All audit outcomes will be presented to	9/1/15

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F 456	Continued From page 37 of the fan. The condensation was also observed on a plastic knob next to the door. The ice build up on the knob was approximately three inches long. On the floor next to the door, an area of ice build up was noted to be approximately 2 inches wide, 5 inches long and 2 inches high. - The dishwasher was observed to have a large amount of lime build up on the edges of the machine, on the front door handle and under on the motor under the machine. The lower motor located under the machine was noted to be connected to pipes. A dried towel with a large amount of thick lime build up was observed over the connection between the pipes and the motor. Approximately half of the towel covered the motor. Located on the floor under the motor was a dishpan (approximately 24 inches by 11 inches which was 3-4 inches deep.) The dish pan had a rubber drain hose connected to it which ran from the pan towards a floor drain. The hose was held in place with a 6 inch brick. Water was observed to be slowly dripping from the motor connections into the dish pan. On 7/20/15, at 6:22 p.m. the dietary aide (DA)-A was observed washing dishes with the dishwasher. The water was observed running freely from the motor/pipe connection covered with a towel. The towel was wet. When the machine was running, the towel was lifted slightly and extremely hot water sprayed directly from the machine. The temperature gauge on the machine rinse cycle at that time were noted to be 180 degrees Fahrenheit (F). Water was also observed to be running from the front panel handle On 7/20/15, at 6:25 p.m. DA-A stated she was	F 456	the QAA Committee for comment & review.	

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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
F 456	Continued From page 38	F 456		

unsure how long the towel had been in place to cover the water spraying from the machine. She was unaware if the maintenance department had been made aware of the concern.

On 7/21/15, at 11:30 a.m. the dishwasher was observed with the interim administrator, maintenance director and the cooperate maintenance director. Cook-B was observed to start the dishwasher. The towel over the electric motor/pipe connections was lifted and water again sprayed from under the towel and ran into the dishpan. Cook-B stated she had worked in the kitchen for five months and the towel had been over the dishwasher the entire time. She stated she did not know if the maintenance department had been made aware of the concern. The interim administrator stated he was not aware of any concerns related to the dishwasher. The maintenance director stated he started working at the facility three weeks earlier and he had not been made aware of any concerns related to the dishwasher. The cooperate maintenance director stated he was not aware of the concern with the dishwasher. The cooperate maintenance director stated the dishwasher required attention "immediately."

On 7/22/15, at 11:45 a.m. the dietary manager stated she had started working at the facility on 7/14/15. She confirmed the ice build in the freezer was due to condensation and was in need of being removed. She also stated the maintenance department was working on the dishmachine concerns.

The Dishmachine/Deliming the Dishmachine policy dated 5/17/09, directed staff to delime the dishmachine on a weekly basis. The policy did

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F 456	Continued From page 39 not direct the staff to report concerns related to the dishmachine to the food service director, maintenance director or the facility administrator. The Walk in Freezer policy dated 5/17/09, directed the staff to defrost the freezer annually and not to use sharp utensils when removing ice buildup.	F 456		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean and sanitary cooking and kitchen equipment in the kitchen. This had the potential to affect 26 of 26 residents who received food from the kitchen. Findings include: On 7/20/15, at 2:10 p.m. the initial tour of the kitchen was completed with Cook-B and the following concerns were identified: - The range hood above the stove had a grease build up. However, due to poor lighting, the severity of the build up was difficult to determine. - The convection oven had a thick layer of gray grease and dust.	F 465	1. & 2. The range hood and grates have been cleaned. The convection oven has been cleaned. The steam oven has been cleaned. The divider wall has been cleaned. The griddle has been cleaned. The oven has been cleaned. 3. Dietary staff have been educated on completing posted cleaning schedules. The Dietary Manager will audit these schedules weekly and complete observational audits on all equipment weekly to assure compliance. 4. Audit summaries shall be provided to the QAA Committee for comment & review.	9/1/15

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F 465	Continued From page 40 - The steam oven had a thick layer of grease and dust. - The brick divider wall between the steam ovens and the stove was noted to have a thick layer of grease and dust. - The griddle had a thick layer of grease built up on the sides of the griddle enclosure. - The left oven had a large amount of food spillage down the side of the oven. The food debris included yellow, white and gray drippings. - The stovetop area was noted to have a thick layer of grease and food debris. On 7/21/15, from 3:30 p.m. - 4:00 p.m. the sanitation tour of the kitchen was completed with the dietary manager and the following was observed. - A thick layer of grease and dust debris continued to cover the convection oven, the steam oven and the cement divider between the steam ovens and the stoves. The dietary manager verified the areas were in need of cleaning. - The dietary manager took a metal spatula and scraped the grease and debris off of the griddle barrier. She stated the area needed to be cleaned. - The dietary manager verified there was food spilled down the front of the oven and any food spillage was to be cleaned before the end of the shift.	F 465		

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F 465	Continued From page 41 On 7/22/15, at 11:45 a.m. the dietary manager stated she had located a flashlight and had spent several hours cleaning the hood vent on 7/21/15. She stated she could not remove the hood vent grates to clean them. The grate vents were observed to be covered in thick yellow grease film. The dietary manager verified the vents required further cleaning. The manager stated she had started working at the facility on 7/14/15. The Cleaning Schedule food service policy dated 5/17/09, directed the dietary staff to maintain the sanitation of the food service department through routine cleaning schedules.	F 465		

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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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 Communities Inc. 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 TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2015

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.

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us or 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. This facility was surveyed as one building: Oakland Park Communities Inc. 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 building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 40 beds and had a census of 26 at the time of the survey.	K 000		

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K 000	Continued From page 2	K 000		
K 011 SS=C	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 1 fire separations were found not to be in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect the residents, staff and visitors of the facility. Findings include: On facility tour between 9:00 AM to 1:00 PM on 07/21/2015, observations revealed that the 2-hour fire separation that divides the nursing home from an assistance living unit has a door that is being propped open with a chair and a brick.	K 011	The brick and chair holding door to the assisted living unit were removed on 7/24/15. The Maintenance Supervisor corrected this deficiency and is responsible for preventing a reoccurrence of the deficiency.	7/24/15

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K 011	Continued From page 3 This deficient condition was verified by the Maintenance Supervisor (SC).	K 011		
K 018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) section 19.3.6.3.3. This deficient practice could affect the safety of all residents, staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include:	K 018	The cross-corridor doors next to the nurses' station were removed by the Maintenance Supervisor on 8/7/15. They will not be replaced and the Maintenance Supervisor will ensure this.	8/7/15

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K 018	Continued From page 4 On facility tour between 9:00 AM to 1:00 PM on 07/21/2015, it was observed that there were wedges holding open a set of cross-corridor doors that are located next to the main nurses station. This deficient condition was verified by the Maintenance Supervisor (SC).	K 018		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include:	K 025	The space around the communication cables passing through the smoke barrier wall located above the smoke barrier doors by resident room 121 were caulked with fire caulking on 7/24/15 by the Maintenance Supervisor. Maintenance Supervisor will monitor for other similar deficiencies.	7/24/15

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K 025	Continued From page 5 On facility tour between 9:00 AM to 1:00 PM on 07/21/2015, observation revealed that there were penetrations found around communication cables that are passing through the smoke barrier wall located above the smoke barrier doors by resident room 121. This deficient condition was verified by the Maintenance Supervisor (SC).	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could	K 029	The handle on the soiled utility room 136D was fixed so it positively latched into the door frame on 7/24/15 by the Maintenance Supervisor. The Maintenance Supervisor will monitor building for other handles that do not latch and fix any that he finds.	7/24/15

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K 029	Continued From page 6 negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 9:00 AM to 1:00 PM on 07/21/2015, observation revealed, that the door latch on the fire rated door for the soiled utility room 136D was inoperative and did not allow the door to positively latch into the door frame. This deficient condition was verified by the Maintenance Supervisor (SC).	K 029		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The deficient practice could affect residents, staff and visitors, if the lack of properly illuminated exit sign prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include:	K 047	The light bulb in exit light by room 135 was replaced by Maintenance Supervisor on 7/24/15. All exit light signs will be monitored by Maintenance Supervisor to prevent future deficiencies.	7/24/15

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K 047	Continued From page 7 On facility tour between 9:00 AM to 1:00 PM on 07/21/2015, it was observed that the exit light by storage room 135 was inoperative (not illuminated) at the time of the inspection. This deficient condition was verified by the Maintenance Supervisor (SC).	K 047		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 9:00 AM to 1:00 PM on 07/21/2015, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility.	K 054	Documentation for sensitivity test for smoke detection devices was obtained on 7/24/15. Maintenance Supervisor will monitor for compliance.	7/24/15

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K 054	Continued From page 8 This deficient condition was verified by the Maintenance Supervisor (SC).	K 054		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Observations revealed that the facility failed to maintain the required clearances between oxygen administration requirement from heat/ignition sources in accordance with NFPA 99 Standards for Health Care Facilities (1999 edition) sections 8-2.1.2.3 and 8-2.1.2.4(d). This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 9:00 AM to 1:00 PM on 07/21/2015, observations revealed that in the facility's beauty shop a resident who was on oxygen therapy via nasal cannula that was	K 076	Policy concerning using oxygen in beauty salon was reviewed and updated. Staff will be educated on the policy on 8/19/15. DON or designee will monitor for compliance.	8/19/15

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K 076	Continued From page 9 supplied by a portable E-size oxygen tank was wheeled in and placed near bonnet style hair dryer that has 110 volt convenience outlet features built into the dryer. An interview with the Interim Administrator (TA), reveled that the facility has a oxygen use policy for the beauty shop but on this event the beauty shop did not follow that policy. This deficient condition was verified by the Interim Administrator (TA).	K 076		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was not maintaining the facility's electrical devices in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors of the facility. Findings include: On facility tour between 9:00 AM to 1:00 PM on 07/21/2015, observations revealed the following conditions were found to be affecting the electrical systems: 1. There was combustible items being stored on and around the 480v transformers that are located in the maintenance shop	K 147	Combustible items being stored on and around 480v transformers in maintenance shop were removed by Maintenance Supervisor on 7/24/15. Combustible rag located around electrical components of dish washer water pump was removed and dish washer was fixed on 7/29/15. Maintenance Supervisor will continue to monitor.	7/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2015**

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 147	Continued From page 10 2. there was a combustible rag located around the electrical components of the dish washer water pump that is being used to deflect water into a basin that is located under the pump. This deficient condition was verified by the Maintenance Supervisor (SC).	K 147		