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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TO4K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00120

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245398**

2.STATE VENDOR OR MEDICAID NO.
(L2) **187918900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKER OAKS COMMUNITIES INC**
(L4) **211 6TH STREET NORTHWEST**
(L5) **WINNEBAGO, MN** (L6) **56098**

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) **04/20/2006**

6. DATE OF SURVEY **03/25/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NEII 04/01/20103 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 05/22/2013 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 5/31/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/01/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On March 25, 2013, a Post Certification Revisit was completed to verify correction of deficiencies issued pursuant to the January 7, 2013 standard survey and not corrected at the time of the March 1, 2013 PCR. The March 25, 2013 PCR verfied correction as of March 25, 2013. Refer to the CMS 2567b form for health only.

Effective March 25, 2013, the facility is certified for 35 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5398

May 22, 2013

Mr.. Christopher Knoll, Administrator
Parker Oaks Communities Inc
211 6th Street Northwest
Winnebago, Minnesota 56098

Dear Mr.. Knoll:

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 March 25, 2013 the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8427

April 3, 2013

Mr.. Christopher Knoll, Administrator
Parker Oaks Communities Inc
211 6th Street Northwest
Winnebago, Minesota 56098

RE: Project Number S5398024

Dear Mr.. Knoll:

On March 13, 2013, This Department recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy for imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 7, 2013. (42 CFR 488.417 (b))

In accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 7, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on January 7, 2013 and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 1, 2013. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On March 25, 2013, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 7, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 1, 2013, as of March 25, 2013. As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 13, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 7, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 7, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 7, 2013, is to be rescinded.

In our letter of March 13, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 7, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 25, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5398r2_13.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245398	A. Building B. Wing	3/25/2013

Name of Facility	Street Address, City, State, Zip Code
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

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 **F0323** Reg. # **483.25(h)** LSC	**03/25/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/MK	Date: 04/03/2013	Signature of Surveyor: 28591	Date: 03/25/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/7/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00120	A. Building B. Wing	3/25/2013

Name of Facility	Street Address, City, State, Zip Code
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	**03/25/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/MK	04/03/2013	28591	03/25/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/7/2013

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: TO4K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00120

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245398**

2.STATE VENDOR OR MEDICAID NO.
(L2) **187918900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKER OAKS COMMUNITIES INC**
(L4) **211 6TH STREET NORTHWEST**
(L5) **WINNEBAGO, MN** (L6) **56098**

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) **04/20/2006**

6. DATE OF SURVEY **03/01/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:

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
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Whitlock, HFE NEII 03/15/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/07/2013 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 4/12/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/01/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5398

On March 1, 2013, a Post Certification Revisit (PCR) was completed by the Department of Health and February 8, 2013, the Minnesota Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility has not achieved substantial compliance with the health deficiencies pursuant to the January 1, 2013 standard survey. Refer to the CMS-2567 (For health), CMS 2567b for both health and life safety code.

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Verbally informed provider on 03252013
Scanned to provider 04012013

Mr. Christopher Knoll, Administrator
Parker Oaks Communities Inc
211 6th Street Northwest
Winnebago, Minnesota 56098

Re: Project # S5398024

Dear Mr. Knoll:

On March 1, 2013, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 7, 2013 with orders received by you on January 25, 2013.

State licensing orders issued pursuant to the last survey completed on January 7, 2013 and found corrected at the time of this March 1, 2013 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on January 7, 2013, found not corrected at the time of this March 1, 2013 revisit and subject to penalty assessment are as follows:

20830 - MN Rule 4658.0520 Subp. 1 - $350.00 - Adequate And Proper Nursing Care; General

The details of the violations noted at the time of this revisit completed on March 1, 2013 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the following address, Maria King Minnesota Department of Health Mankato Place 12 Civic Center Plaza Suite #2105 Mankato Minnresota 56001-7789. If you have questions regarding the written notification, Maria can be reached at (507) 344-2716.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to

verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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 letter.

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File
Maria King, Mankato District Office Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8335

March 13, 2013

Mr. Christopher Knoll, Administrator
Parker Oaks Communities Inc
211 6th Street Northwest
Winnebago, Minnesota 56098

RE: Project Number S5398024

Dear Mr. Knoll:

On January 22, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 7, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On March 1, 2013, the Minnesota Department of Health and on February 8, 2013, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 7, 2013. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 7, 2013. The deficiency not corrected is as follows:

F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 7, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 7, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 7, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Parker Oaks Communities Inc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 7, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

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

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:

Maria King
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789

Telephone: (507) 344-2716
Fax: (507) 344-2723

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 July 7, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

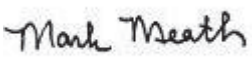
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Sincerely,



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

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245398	A. Building B. Wing	3/1/2013

Name of Facility	Street Address, City, State, Zip Code
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **03/01/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/01/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/01/2013**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/01/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/01/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/01/2013**
ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **03/01/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/MK	03/13/2013	28588	03/01/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/7/2013			

PRINTED: 03/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245398	A. BUILDING _____ B. WING _____	R 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(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. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	(F 000)		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to maintain a safe environment for 1 of 1 resident (R7) who smoked cigarettes. Findings include: R7 continued to smoke without direct supervision of facility staff and often refused to utilize a smoking apron. R7's cigarettes were not being kept in the medication cart per the plan of correction..	F 323	Parker Oaks Communities Inc. F 323 Parker Oaks Communities Inc. must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	

POC accepted mtg ej 3/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X5) DATE
	Administrator	03/15/2013

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

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

PRINTED: 03/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245398	A. BUILDING _____ B. WING _____	R 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 During interview with the director of nursing (DON) on 3/1/13 at 12:35 p.m., the DON stated the facility now kept R7's cigarettes in the medication cart and that facility staff supervised her at all times when she was smoking. During the interview, the DON had a cigarette pouch sitting on the desk in her office. When asked about it, the DON stated "those are the cigarettes we took out of her (R7's) room." During observations of R7 on 3/1/13 at approximately 12:55 p.m., the resident was seated in a chair in her room with a pack of cigarettes observed on her bedside table. When questioned about use of the smoking apron and supervision, R7 said that she had to "do it just for today and then it will go back to normal." When asked who had told her that, R7 identified the administrator. Review of R7's record indicated R7 had tried using electronic cigarettes, but had then refused to use them. In addition, the record indicated the resident's smoking materials were to be stored in the first floor medication cart, and that staff were supposed to supervise her when she went outside to smoke, because she continued to be non-compliant with the smoking apron. There were several nurses' notes in the record about R7's refusals to keep her cigarettes in the medication cart, her going out to smoke without supervision, and her refusal to wear the smoking apron. During interview with the DON on 3/1/13 at approximately 1:00 p.m., she was informed that R7 had a pack of cigarettes on the the bedside	F 323	R7 has had a comprehensive assessment done on 3/6/13 to update her current status. R7 is the only smoker in the facility and has had a full smoking assessment done on 3/6/13. The resident's family has been informed that it is imperative that they bring smoking paraphernalia to staff and have signed a statement on 3/15/13 stating they are aware. Parker Oaks has noted all clothes with cigarette burns to verify no new burns have been acquired. Staff will accompany resident 100 percent of the time to ensure safe smoking practices. Treatment sheets have been updated to direct staff to check for smoking paraphernalia on AM and PM shifts daily. Smoking paraphernalia will be stored in a central location away from resident.	

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

PRINTED: 03/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245398	A. BUILDING _____ B. WING _____	R 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 table in her room. The DON stated, "the family must have just brought them to R7". During an interview with an assisted living staff, staff-A on 3/1/13 at 1:10 p.m., staff-A stated she had noticed that facility staff had started to go out with R7 more routinely, but that she (staff-A) had still seen R7 smoking outside by herself at times without staff supervision. Interview with licensed practical nurse (LPN)-A on 3/1/13 at 1:15 p.m., verified that R7 goes out by herself to smoke. LPN-A stated that the staff know that R7 is not supposed to go outside and smoke unsupervised, but that R7 continued to do so and refused to wear the smoking apron. LPN-A also said that R7 kept her cigarettes in her room. LPN-A said the staff attempted to keep the resident's cigarettes in the medication cart, but R7 had requested them back so they had given them back to her. LPN-A further verified that staff weren't going outside with R7 each time she went outside to smoke. She said, "we can't, we don't have the staff to go with her everytime she goes out and they just cut our hours again. The staff kept her cigarettes in the medication cart maybe a week or so then R7 had them back in her possession." During an interview with trained medication aid (TMA)-A on 3/1/13 at 1:20 p.m., TMA-A stated that R7 refused the smoking apron for a lot of staff but she will put it on for her sometimes. TMA-A further verified that R7 kept cigarettes in her room and that someone did not always go out with her when she smoked. The DON and administrator were interviewed on 3/1/13 at 1:30 p.m. The DON stated R7's "cigarettes are always in my office with her lighter, and in the evening her cigarettes are kept in the	F 323	Staff will be educated on the importance of having someone supervise the resident. Education will be finished on 3/20/13. The following will be audited daily x1 week. 3x a week or until 100 percent compliance is met. Date Compliant: 3/20/13	

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

PRINTED: 03/15/2013
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245398	A. BUILDING _____ B. WING _____	R 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 medication cart." The administrator stated that staff who smoke always come to get R7 when they take a cigarette break. He further added that he knows for certain that he has staff on duty 7 days a week/24 hours a day who are smokers themselves and that those staff always offer to take R7 with them when they smoke in order to supervise her. The DON stated that in her opinion R7 understood the smoking contract that she'd signed. Both the DON and administrator stated that R7 either wears her apron, or is supervised by staff, at all time when she is smoking. During a telephone interview with the social services designee (SSD) on 3/1/13 at 2:00 p.m., the SSD stated the only staff who take R7 outside to smoke were the administrator and her. The SSD stated that she would routinely put the smoking apron on R7 when she took her outside to smoke, but that she does not stay and supervise her. The SSD acknowledged that that R7 was capable of removing the smoking apron. In addition, the SSD stated that sometimes the administer would sit with R7, and stated staff didn't always sit outside with her but verified some staff did take her out with them when they went out to smoke. She further stated that R7 had begun smoking more since this all came up. The SSD stated, "when R7 refused the smoking apron and went out by herself to smoke without supervision, we explained to R7 that it was not safe for her, but it was her right to refuse." The SSD verified that R7 probably wasn't safe if she didn't wear the smoking apron.	F 323		

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245398	A. Building B. Wing **01 - MAIN BUILDING 01**	2/8/2013

Name of Facility	Street Address, City, State, Zip Code
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

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 Reg. # **NFPA 101** LSC K0011	Correction Completed **02/07/2013**	ID Prefix Reg. # **NFPA 101** LSC K0025	Correction Completed **01/15/2013**	ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **01/23/2013**
ID Prefix Reg. # **NFPA 101** LSC K0062	Correction Completed **01/30/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** MM/PS	**Date:** 03/11/2013	**Signature of Surveyor:** 25822	**Date:** 02/08/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/3/2013

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00120	A. Building B. Wing	3/1/2013

Name of Facility	Street Address, City, State, Zip Code
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **03/01/2013**	ID Prefix **20555** Reg. # **MN Rule 4658.0405 Subp. 1** LSC	Correction Completed **03/01/2013**	ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp. 2.B** LSC	Correction Completed **03/01/2013**
ID Prefix **21325** Reg. # **MN Rule 4658.0725 Subp. 1** LSC	Correction Completed **03/01/2013**	ID Prefix **21415** Reg. # **MN Rule 4658.0815 Subp. 2** LSC	Correction Completed **03/01/2013**	ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	Correction Completed **03/01/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/MK	03/13/2013	28588	03/01/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/7/2013			

PRINTED: 03/15/2013
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00120	A. BUILDING: _____ B. WING _____	R 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(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) COMPLETE DATE
(2 000)	Initial Comments *****ATTENTION******* NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On March 1, 2013 surveyors of this Department's staff, visited the above provider and the following correction order was re-issued. When the correction is completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	(2 000)		

PRINTED: 03/15/2013
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00120	A. BUILDING: _____ B. WING _____	R 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(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) COMPLETE DATE
(2 000)	Continued From page 1 Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001	(2 000)		
(2 830)	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to maintain a safe environment for 1 of 1 resident (R7) who smoked cigarettes. Findings include: R7 continued to smoke without direct supervision of facility staff and often refused to utilize a smoking apron. R7's cigarettes were not being kept in the medication cart per the plan of correction.. During interview with the director of nursing (DON) on 3/1/13 at 12:35 p.m., the DON stated the facility now kept R7's cigarettes in the medication cart and that facility staff supervised	(2 830)		

PRINTED: 03/15/2013
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00120	A. BUILDING: _____ B. WING _____	R 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(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) COMPLETE DATE
(2 830)	Continued From page 2 her at all times when she was smoking. During the interview, the DON had a cigarette pouch sitting on the desk in her office. When asked about it, the DON stated "those are the cigarettes we took out of her (R7's) room." During observations of R7 on 3/1/13 at approximately 12:55 p.m., the resident was seated in a chair in her room with a pack of cigarettes observed on her bedside table. When questioned about use of the smoking apron and supervision, R7 said that she had to "do it just for today and then it will go back to normal." When asked who had told her that, R7 identified the administrator. Review of R7's record indicated R7 had tried using electronic cigarettes, but had then refused to use them. In addition, the record indicated the resident's smoking materials were to be stored in the first floor medication cart, and that staff were supposed to supervise her when she went outside to smoke, because she continued to be non-compliant with the smoking apron. There were several nurses' notes in the record about R7's refusals to keep her cigarettes in the medication cart, her going out to smoke without supervision, and her refusal to wear the smoking apron. During interview with the DON on 3/1/13 at approximately 1:00 p.m., she was informed that R7 had a pack of cigarettes on the the bedside table in her room. The DON stated, "the family must have just brought them to R7". During an interview with an assisted living staff, staff-A on 3/1/13 at 1:10 p.m., staff-A stated she had noticed that facility staff had started to go out with R7 more routinely, but that she (staff-A) had	(2 830)		

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FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00120	A. BUILDING: _____ B. WING _____	R 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(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) COMPLETE DATE
(2 830)	Continued From page 3 still seen R7 smoking outside by herself at times without staff supervision. Interview with licensed practical nurse (LPN)-A on 3/1/13 at 1:15 p.m., verified that R7 goes out by herself to smoke. LPN-A stated that the staff know that R7 is not supposed to go outside and smoke unsupervised, but that R7 continued to do so and refused to wear the smoking apron. LPN-A also said that R7 kept her cigarettes in her room. LPN-A said the staff attempted to keep the resident's cigarettes in the medication cart, but R7 had requested them back so they had given them back to her. LPN-A further verified that staff weren't going outside with R7 each time she went outside to smoke. She said, "we can't, we don't have the staff to go with her every time she goes out and they just cut our hours again. The staff kept her cigarettes in the medication cart maybe a week or so then R7 had them back in her possession." During an interview with trained medication aid (TMA)-A on 3/1/13 at 1:20 p.m., TMA-A stated that R7 refused the smoking apron for a lot of staff but she will put it on for her sometimes. TMA-A further verified that R7 kept cigarettes in her room and that someone did not always go out with her when she smoked. The DON and administrator were interviewed on 3/1/13 at 1:30 p.m. The DON stated R7's "cigarettes are always in my office with her lighter, and in the evening her cigarettes are kept in the medication cart." The administrator stated that staff who smoke always come to get R7 when they take a cigarette break. He further added that he knows for certain that he has staff on duty 7 days a week/24 hours a day who are smokers themselves and that those staff always offer to take R7 with them when they smoke in order to supervise her. The DON stated that in her opinion R7 understood the smoking contract that	(2 830)		

PRINTED: 03/15/2013
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(2 830)	Continued From page 4 she'd signed. Both the DON and administrator stated that R7 either wears her apron, or is supervised by staff, at all time when she is smoking. During a telephone interview with the social services designee (SSD) on 3/1/13 at 2:00 p.m., the SSD stated the only staff who take R7 outside to smoke were the administrator and her. The SSD stated that she would routinely put the smoking apron on R7 when she took her outside to smoke, but that she does not stay and supervise her. The SSD acknowledged that that R7 was capable of removing the smoking apron. In addition, the SSD stated that sometimes the administer would sit with R7, and stated staff didn't always sit outside with her but verified some staff did take her out with them when they went out to smoke. She further stated that R7 had begun smoking more since this all came up. The SSD stated, "when R7 refused the smoking apron and went out by herself to smoke without supervision, we explained to R7 that it was not safe for her, but it was her right to refuse." The SSD verified that R7 probably wasn't safe if she didn't wear the smoking apron. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review and revise policies, and could re-educate staff to ensure that all residents are assessed and provided necessary supervision, care and services. They could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	(2 830)		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TO4K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00120

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245398**

2.STATE VENDOR OR MEDICAID NO.
(L2) **187918900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKER OAKS COMMUNITIES INC**
(L4) **211 6TH STREET NORTHWEST**
(L5) **WINNEBAGO, MN** (L6) **56098**

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) **04/20/2006**

6. DATE OF SURVEY **01/07/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:

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	IMR
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

At the time of the January 7, 2013 standard survey. survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Mary Whitlock, HFE NEII 02/15/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 02/28/2013 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/01/2013 CO. TO4K

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9127

January 22, 2013

Ms. Dorothy Baker, Administrator
Parker Oaks Communities Inc
211 6th Street Northwest
Winnebago, Minnesota 56098

RE: Project Number S5398024

Dear Ms. Baker:

On January 7, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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:

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

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

<u>Remedies</u> - 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:

Maria King
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001

Telephone: (507) 344-2716

Fax: (507) 344-2723

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 February 16, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 7, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 7, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

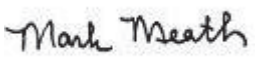
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Licensing and Certification File 5398s13.rtf

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

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	F – 157 See F – 309 RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato Receipt mk 2/5/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin. | (X6) DATE: 2-1-13

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

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to notify the physician when a resident experienced abnormal bleeding from the gastrointestinal tract for 1 of 3 resident (R39) reviewed for hospitalization. The findings include: R39 was admitted to the facility with anemia (low iron levels in the blood-identified by laboratory values of low hemeglobin and hematocrit). The resident subsequently experienced blood in his feces during bowel movements. The physician was not notified of this change in the resident's condition. R39 was admitted to the facility from the hospital on 12/4/12, following repair of a fractured left hip. Review of medical record documents provided to the facility from the hospital, revealed R39 had a low hemoglobin and hematocrit upon admission to the nursing home. The hospital records indicated R39 had a hemoglobin of 13.3 (normal value would be 13.5 to 17.5 for males) on the day of admission to the hospital 11/26/12. However, further review of the hospital records indicated R39's hemoglobin values dropped and continued	F 157		

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F 157	Continued From page 2 to be below the normal reference range during his stay at the hospital. Documented lab values included a hemoglobin of 11.8 and a hematocrit of 35.6 (normal reference value 38.8 to 50) on 11/27/12; hemoglobin of 8.8 and hematocrit of 27.7 on 11/28/12; hemoglobin of 9.7 and hematocrit of 29.7 on 11/29/12; hemoglobin of 8.4 and hematocrit of 27 on 11/30/12; hemoglobin of 8.1 and hematocrit of 24.8 on 12/2/12; and on 12/4/12, the day of the resident's admission to the nursing home, documents indicated the resident's hemoglobin was 7.7 and hematocrit was 23.6. The hospital record documents also indicated R39 upheld Jehovah Witness religious beliefs and had refused blood products to treat the anemia. However, review of the hospital reports confirmed R39 had received an oral iron supplement while hospitalized. R39 had received ferrous sulfate 324 mg (milligrams) twice a day on 11/28/12, 11/ 29/12, 11/30/12 and 12/1/12. The medication had then been switched to Niferex 150 mg daily and the resident had received that medication on 12/2/12 and 12/3/12. Review of the nursing home record revealed R39 received no iron supplementation following admission to the nursing home. In addition, there was no documentation the facility had contacted the physician regarding the use of any iron supplements for R39 while at the nursing home. Review of the nursing home nurses notes revealed an entry dated 12/5/12, "to commode for BM [bowel movement]. Passed an almost black moderate BM with dark red blood passed also, less than 30 cc [cubic centimeters]." There was no documentation in the medical record demonstrating the physician had been made	F 157		

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F 157	Continued From page 3 aware of R39's dark and bloody stool. On 12/8/12, there was again documentation of a dark bloody stool, "up to commode per stand-up lift for BM [bowel movement]. Passed a large stool with blood accompanying it." Again, there was no documentation the facility notified the physician of the bloody stool. On 12/16/12, the nurses' notes revealed R39 had a fever of 103.3 degrees Fahrenheit (F) at the time of his morning cares and was unable to follow directions. The next entry in the notes was at 4:00 p.m. when the nurse documented, "Resident up in bed denies pain at this point in time. Shows signs of decreased level of consciousness, temp. 100.8, skin warm, dry and pale in color. BP [blood pressure] 78/55, shows no signs of anxiety or respiratory distress, oxygenation 92% at 2 liters per minute. Respirations 16, consumed 10% of dinner. Sent to ER [emergency room] to treat and evaluate." The resident had not returned to the facility. When interviewed on 1/4/13, at 2:15 p.m. the director of nursing (DON) stated the resident had been transferred to the hospital and had died there. When asked about R39's low hemoglobin and hematocrit at the time of his admission, the DON acknowledged that when staff had noticed no iron supplement was ordered, she would have expected the nursing staff to call the physician to clarify whether iron supplementation should be provided to the resident. The DON also added that she'd been unaware R39 had experienced dark and bloody stools while at the facility. She stated she would have expected the nurses to call the physician to report the abnormal stools.	F 157		

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	245398	A. BUILDING _____ B. WING _____	01/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

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F 157	Continued From page 4 The facility's policy and procedure, Physician Communication Policy and Procedure, included; "It is the policy of Parker Oaks Communities to communicate changes in residents' condition to the MD in a timely manner, so that the highest quality of care possible can be delivered. It is the responsibility of the licensed charge nurse to give notification of resident status." Situations listed in the policy as to when the physician would be telephoned included abnormal bleeding.	F 157		
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). This REQUIREMENT is not met as evidenced by: Based on document review and interview, the	F 279	F – 279 It is the policy of Parker Oaks Communities Inc. to develop comprehensive care plans based on assessment and to review and revise the care plan as needed. R26's and similar concerns related to sleep and sleep meds have been reviewed and updated on 1/29/13 by D.O.N specifically in regards to sleep hygiene. Sleep diaries for residents who take any medication to aid sleep have been completed on 2/1/13 to ensure lowest effective dose is being administered. RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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F 279	Continued From page 5 facility failed to develop a comprehensive care plan for 1 of 10 residents (R26) in the sample reviewed for unnecessary medication use. Findings include: R26 did not have a comprehensive care plan developed within 21 days of admission. R26 was admitted to the facility on 11/28/12 with diagnoses including: dementia, panic attacks, hypothyroidism, chronic anemia, anxiety, cardiomegaly, hypercholesterolemia, hypertension and depression. Medical record review for medication usage indicated R26 received medications including Lasix (a diuretic), Lisinopril and Metoprolol (antihypertensives), Levothyroxine (thyroid medication), Latvian (anti-anxiety), Zoloft and Trazadone (antidepressants) and Fergon (iron). During additional review of the record to determine whether there were adequate indications for use, or regular monitoring for efficacy/side effects, it was noted there was had been no comprehensive care plan developed for the resident. Only a 'daily needs/functional care plan,' a check list of ADL's (activities of daily living), communication, hearing, vision, cognition and behavioral symptoms was available in the medical record. No comprehensive care plan had been developed to determine interventions for the resident's care. The director of nursing was interviewed on 1/3/13 at 6:35 p.m. She verified there had been no comprehensive care plan developed for R26 since admission admission 34 days prior.	F 279	Nursing staff members will be required to attend a mandatory in service on 2/7/13 that will cover the following topics, development, review, and revision of the resident's care plan. Education will also include the assessment process and using the care plan for providing resident cares. D.O.N or A.D.O.N is responsible for overall compliance of this regulation. Random weekly audits with 25% of residents' charts being pulled will be performed for one month and bi-weekly for the next month or until compliance is met on care plans, assessment content, and provisions of cares according to the care plan. Results will be reviewed by the Quality Council and changes made based on audit results will be recommended. Date Compliant: 2/7/13 RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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F 309 SS=G	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 document review and interview, the facility failed to seek medical direction and/or treatment for abnormal bleeding from the gastrointestinal (GI) tract for 1 of 3 resident (R39) reviewed for hospitalization. These factors resulted in harm for R39, who required hospitalization for this issue and later died. In addition, the facility failed to recognize and treat pain related to a dental condition for 1 of 3 residents (R30) reviewed for dental services. The findings include: R39 was admitted to the facility with anemia (low iron levels in the blood-identified by laboratory values of low hemeglobin and hematocrit). The resident subsequently experienced blood in his feces during bowel movements. The facility did not seek direction or treatment for this condition. R39 was admitted to the facility from the hospital on 12/4/12, following repair of a fractured left hip. Review of medical record documents provided to the facility from the hospital, revealed R39 had a low hemoglobin and hematocrit upon admission to the nursing home. The hospital records	F 309	F – 309 It is the intent of the Parker Oaks Communities Inc. to provide care/services for the highest well being. Since the survey team exited the facility R39 has passed away. R30's care plan has been updated on 2/1/13 to reflect family declines for further dental exams. Facility will continue to offer exams annually and as needed. The facility protocol states all significant changes in condition must be reported to resident's primary physician. All nursing staff members will be required to attend an in service session on 2/7/13 that will cover the following topic physician notification of changes in condition. Staff members who are unable to attend will be required to meet with D.O.N or A.D.O.N to go over information on an individual basis. RECEIVED FEB 0 6 2013 Minnesota Dept of Health Mankato	

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F 309	Continued From page 7 indicated R39 had a hemoglobin of 13.3 (normal value would be 13.5 to 17.5 for males) on the day of admission to the hospital 11/26/12. However, further review of the hospital records indicated R39's hemoglobin values dropped and continued to be below the normal reference range during his stay at the hospital. Documented lab values included a hemoglobin of 11.8 and a hematocrit of 35.6 (normal reference value 38.8 to 50) on 11/27/12; hemoglobin of 8.8 and hematocrit of 27.7 on 11/28/12; hemoglobin of 9.7 and hematocrit of 29.7 on 11/29/12; hemoglobin of 8.4 and hematocrit of 27 on 11/30/12; hemoglobin of 8.1 and hematocrit of 24.8 on 12/2/12; and on 12/4/12, the day of the resident's admission to the nursing home, documents indicated the resident's hemoglobin was 7.7 and hematocrit was 23.6. The hospital record documents also indicated R39 upheld Jehovah Witness religious beliefs and had refused blood products to treat the anemia. However, review of the hospital reports confirmed R39 had received an oral iron supplement while hospitalized. R39 had received ferrous sulfate 324 mg (milligrams) twice a day on 11/28/12, 11/ 29/12, 11/30/12 and 12/1/12. The medication had then been switched to Niferex 150 mg daily and the resident had received that medication on 12/2/12 and 12/3/12. Review of the nursing home record revealed R39 received no iron supplementation following admission to the nursing home. In addition, there was no documentation the facility had contacted the physician regarding the use of any iron supplements for R39 while at the nursing home. Review of the nursing home nurses notes revealed an entry dated 12/5/12, "to commode for	F 309	This will be audited weekly for one month and bi-weekly for the next 2 months or until compliance has been met. The D.O.N or designee will randomly audit nursing documentation for changes in condition to assure residents status are appropriately being documented and changes reported. Results of the auditing will decide future compliance monitoring and training. Results will be presented at quarterly Quality Council meetings. Quality Council Committee will re-evaluate the need and frequency for continued compliance with this regulation. Date Compliant: 2/7/13 RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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F 309	Continued From page 8 BM [bowel movement]. Passed an almost black moderate BM with dark red blood passed also, less than 30 cc [cubic centimeters]." There was no documentation in the medical record demonstrating the physician had been made aware of R39's dark and bloody stool. On 12/8/12, there was again documentation of a dark bloody stool, "up to commode per stand-up lift for BM [bowel movement]. Passed a large stool with blood accompanying it." Again, there was no documentation the facility notified the physician of the bloody stool. On 12/16/12, the nurses' notes revealed R39 had a fever of 103.3 degrees Fahrenheit (F) at the time of his morning cares and was unable to follow directions. The next entry in the notes was at 4:00 p.m. when the nurse documented, "Resident up in bed denies pain at this point in time. Shows signs of decreased level of consciousness, temp. 100.8, skin warm, dry and pale in color. BP [blood pressure] 78/55, shows no signs of anxiety or respiratory distress, oxygenation 92% at 2 liters per minute. Respirations 16, consumed 10% of dinner. Sent to ER [emergency room] to treat and evaluate." The resident had not returned to the facility. When interviewed on 1/4/13, at 2:15 p.m. the director of nursing (DON) stated the resident had been transferred to the hospital and had died there. When asked about R39's low hemoglobin and hematocrit at the time of his admission, the DON acknowledged that when staff had noticed no iron supplement was ordered, she would have expected the nursing staff to call the physician to clarify whether iron supplementation should be provided to the resident. The DON also added	F 309		

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F 309	Continued From page 9 that she'd been unaware R39 had experienced dark and bloody stools while at the facility. She stated she would have expected the nurses to call the physician to report the abnormal stools. The facility's policy and procedure, Physician Communication Policy and Procedure, included; "It is the policy of Parker Oaks Communities to communicate changes in residents' condition to the MD in a timely manner, so that the highest quality of care possible can be delivered. It is the responsibility of the licensed charge nurse to give notification of resident status." Situations listed in the policy as to when the physician would be telephoned included abnormal bleeding. The facility failed to evaluate and monitor R30's complaints of tooth pain. R30 was admitted to the facility on 5/2/08 with diagnoses including but not limited to Parkinson's disease and dementia. The quarterly minimum data set (MDS) dated 6/28/12 identified the resident experienced, "Mouth or facial pain, discomfort, or difficulty with chewing". Interventions on R30's plan of care, last reviewed 1/2/13, included: "Staff offer dental exams annually & PRN (as needed)". During an interview with R30 on 1/2/13 at 11:55 a.m., R30 reported she'd experienced tooth pain on the lower left (L) side of her mouth. R30 stated she had been having the pain prior to the interview and had reported it to staff, however was unsure how long ago the pain had initially started. During the course of the interview, licensed practical nurse (LPN)-Z entered R30's room to administer medication. R30 reported the	F 309		

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F 309	Continued From page 10 dental pain to LPN-Z at that time. LPN-Z acknowledged R30's report of dental pain and indicated she would look into getting R30 some Tylenol. The resident's record was reviewed. An interdisciplinary note dated 12/14/12 included: "Resident c/o (complained of) tooth pain (arrow pointing up) (L) side, call placed to dentist, they weren't open so message was left for Monday." The pain monitoring flow sheets for December 2012, and January 2013, included no record of the resident's complaints of pain from 12/14/12, or 1/02/13. When interviewed on 1/7/13 at 10:19 a.m., the director of nursing (DON) confirmed that R30's complaints of pain to the nurse on 1/2/13 should have been documented with a chart note, and on the pain monitoring flow sheet, and that there should have been follow up with the resident. When interviewed on 1/7/13 at 11: 05 a.m., LPN-Z confirmed that R30 had complained of tooth pain last week on 1/2/13. LPN-Z verified that she had not followed-up on the dental pain, nor attempts to contact R30's daughter about a potential dental appointment, until just that morning (1/7/13).	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further	F 318		

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F 318	Continued From page 11 decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received range of motion services to maintain function for 1 of 3 residents (R27) reviewed in the sample for range of motion. Findings include: R27 had limited range of motion (ROM) in his upper extremities and the facility did not provide ROM services. During an observation of R27 on 1/3/12 at 5:25 p.m., the resident was observed to have a wrist and knuckle contracture on the left hand. The resident was not observed to utilize a splint. R27's diagnoses included generalized weakness and history of a cerebral vascular accident (CVA) with left sided hemiparesis. The quarterly minimum data set (MDS) dated 11/8/12, identified R27 as requiring extensive assistance for most activities of daily living (ADL's). In addition, R27 was identified with functional limitations of one side, for both upper and lower extremities. Review of the plan of care dated 5/16/12, identified the resident as having an alteration in ADL's related to generalized weakness, activity intolerance secondary to a history of a CVA, with	F 318	F – 318 It is the intent of the Parker Oaks Communities Inc. to provide daily cares in accordance with resident's plan of care. R27 and similarly affected residents have been evaluated by Physical Therapy on 2/1/13 with recommendations for range of motion made. Care plans have been updated to reflect appropriate restorative therapy guidelines. Delivery of care will be audited with all residents receiving Range Of Motion modalities being recommended from Physical Therapy with direct observational audits of care being provided. Audits will be completed by D.O.N or designee 3x a week on morning and evening shifts for one month results of audits will be presented to the Quality Council Committee for ongoing review and recommendations. Date Compliant: 2/7/13	

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F 318	Continued From page 12 left sided hemiparesis and significant right sided weakness. The care plan indicated the resident required extensive assistance with all ADL's. Review of the "Restorative Care Program" notes dated 5/22/12, included a program to maintain R27's functional motion in the upper extremities. The program included directions for passive range of motion to both arms 3 times weekly; and to provide movement in both arms, one at a time, gently forwards, inwards, backwards and to the sides 5 times each. This program had been recommended by the Occupational Therapist when formal therapy services had been discontinued. Although observations were made throughout the survey 1/2, 1/3 and 1/4/13, R27 was not observed to receive any restorative exercises. During interview with registered nurse (RN)-A at 6:35 p.m. on 1/3/12, she stated she thought the facility therapy department provided restorative services for the resident, but was unsure. During interview with nursing assistant (NA)-A at 6: 45 p.m. on 1/3/12, she stated she was unaware of who was responsible for providing restorative nursing for R27. She further confirmed she had never observed the services being provided. During interview with the director of nursing (DON) at 7:00 p.m. on 1/3/12, she indicated the nursing assistants were responsible for providing restorative services for R27. When questioned about which days the resident was supposed to be receive such exercises, the DON was unable	F 318		

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F 318	Continued From page 13 to provide that information. The DON further confirmed that R27's ROM program may not be getting done because there had been no days or times designated for the staff to provide the services. During interview with licensed practical nurse (LPN)-B at 7:15 p.m. on 1/3/12, she stated she thought the licensed staff provided R27's ROM services and that it would be noted on the resident's treatment sheet. However, when LPN-B reviewed R27's treatment sheet with the surveyor, she confirmed the treatment sheets did not indicate that any services were being provided by the licensed staff. LPN-B also confirmed she had not been providing these services for R27. During interview with NA-B at 7:52 a.m. on 1/4/12, she stated she works routinely with R27 and has never provided the ROM exercises. She verified she had been unaware of the recommendations. During interview with NA-C at 8:00 a.m. on 1/4/12, she stated she was unaware of who was responsible for providing ROM to residents and confirmed that she had never provided ROM for R27. During interview with the facility's Occupational Therapist at 10:00 a.m. on 1/4/12, she confirmed R27 had impairments of the upper extremities and that the facility staff should be following her recommendations for restorative nursing to maintain the resident's functional motion.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 14 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide adequate supervision in order to prevent accidents for 1 of 3 residents in the sample (R7) who was identified as being potentially unsafe with smoking. Findings include: R7 was observed to have what appeared to be cigarette burn holes in her clothing. Although facility staff acknowledged the resident's potential for unsafe smoking, they had not implemented supervision of her smoking to prevent accidents. R7 was admitted to the facility 8/24/11 with diagnosis including chronic tobacco abuse, chronic obstructive pulmonary disease, dementia and anxiety. During interview and observation of R7 on 1/2/13, at 11:16 a.m. it was noted that she had numerous cigarette burn holes in her slacks. When asked what had happened, she stated she didn't know how the holes got there and also stated that her son told her he was going to take her cigarettes away from her because of the holes. R7 was	F 323	F – 323 It is the intent of Parker Oaks Communities Inc. to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. R7's care plan has been updated to reflect current status. R7 has been informed of facility policy and procedure. The facility has got a contract with the resident to ensure the safety of the resident. The resident acknowledges the contract and will comply with the contract. Electronic Cigarettes will be used by the resident. Random observational audits will be completed weekly for one month to ensure safe smoking practices are being followed. Staff will be educated on the new smoking contract on 2/7/13. Date Compliant: 2/7/13	

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F 323	Continued From page 15 noted to have a pack of cigarettes and a lighter in her pocket. During additional observations on 1/3/13 and 1/4/13, R7 was noted to have small holes in the slacks she was wearing. R7's record was reviewed. The quarterly Minimum Data Set (MDS) dated 8/30/12, indicated a BIMS (Brief Interview for Mental Status) score of 6 which indicated the resident had severe cognitive impairment. A subsequent quarterly MDS dated 11/29/12, indicated a BIMS score of 00 which also indicated severe cognitive impairment. An initial smoking evaluation dated 8/24/11, indicated R7 was alert and oriented to person, place and time, does not want to quit smoking, had been informed of the facility's smoking policy, followed the facility smoking policy (smokes in designated areas, follows schedule, does not smoke when oxygen is present etc.), can safely utilize the lighter/matches and light smoking material, does not use a smoking apron and demonstrates safe smoking practices with other residents. The evaluation identified R7 as being independent. An updated smoking assessment dated 9/25/12, indicated: "Other: Burning holes in clothing - must now wear smoking apron when she goes outside." A nurse's note from 9/25/12 included, "As a result of unsafe smoking practices, resident has been instructed and educated on proper use of smoking apron and why it is needed to maintain her safety. Resident is AAO x 3 (alert and orientated to person, place and time) and states she wishes to continue smoking. She verbalized that she understands why she needs to wear the apron. Staff will monitor that she wears the apron and continue to	F 323		

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	245398	A. BUILDING _____ B. WING _____	01/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

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F 323	Continued From page 16 provide ongoing education to resident." A nurse's note dated 9/28/12, indicated the resident had occasionally been non-compliant with the use of the smoking apron. The note further indicated staff had explained the risks of not using the apron to R7, and that she had indicated she knew this and "doesn't care." Staff was to continue to provide encouragement to the resident to utilize the smoking apron. According to a nursing note from 10/17/12, the resident had been observed outside smoking without the smoking apron. Staff had provided education and indicated they would continue to monitor. The resident's care plan was updated 9/25/12 to include: "Risk for injury R/T (related to) unsafe smoking practices and occasional non-compliance with wearing smoking apron." The approaches included, "Ongoing education will be provided by staff regarding safe smoking practices. Staff will encourage resident to wear smoking apron every time she goes outside to smoke." The facility's SMOKING EVALUATION POLICY AND PROCEDURE dated 5/14/08 included: "PURPOSE: It is the decision of the facility how, when and where to allow smoking and a decision by the resident to smoke. However, residents need to smoke safely and this assessment may assist the facility in making this decision. POLICY: It is the policy that all residents who want to smoke are evaluated and assessed for smoking safety. PROCEDURE: 1. The assessment is to be used at the time of admission and PRN (as needed). 2. The smoking evaluation form will be completed by the charge nurse, case manager or MDS nurse. 3.	F 323		

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F 323	Continued From page 17 Form is used to gather information ...when there is a concern over the resident's behavior and safety smoking. 4. Include the resident and responsible party as indicated." R7 was observed on 1/4/13 at 11:20 a.m., to be in her room counting her cigarettes. When questioned by the surveyor at that time, the resident stated she goes outside "a lot." During an interview with the director of nursing (DON) on 1/4/13 at 11:15 A.M., she stated the resident goes out to smoke whenever she wants to. She stated that the resident and family had risks and benefits of unsafe smoking explained to them and that R7 "does what she wants and won't let us help her at all." When the DON was asked about the resident keeping cigarettes and lighters on her person the DON responded, "I don't know about that, we have a smoking policy" and shrugged her shoulders. On 1/4/13 at 1:30 p.m., R7 was observed going to the smoking area. This smoking area was located outside on the backside of the facility. The area was not near the nursing facility but by the attached assisted living. R7 did not have the smoking apron on. She was observed to light and smoke the entire cigarette without dropping any ashes in her lap. During this observation, there were no staff present in the area to supervise. Licensed practical nurse (LPN)-A was interviewed on 1/4/13 at 1:30 p.m. LPN-A verified that R7 goes out to smoke a lot, "especially when she's bored." When asked whether anyone watches R7 while she smokes, LPN-A stated, "oh no, she goes by herself." When asked if R7 wears the	F 323		

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F 323	Continued From page 18 smoking apron, LPN-A stated that R7 was supposed to wear the apron but often refuses. "If we put it on her she rips it off." During interview with the administrator on 1/4/13 at 1:45 p.m., the administrator stated the facility was currently using the policy from May of 2008, but that they would be implementing a new smoking policy going forward. During an additional interview with the DON on 1/4/13 at 1:55 p.m., the DON verified that R7 may not be safe to smoke independently as evidenced by the holes in her clothing. She stated that the resident does not allow staff to sit with her while she smokes because she is "embarrassed by that." When asked if they could stand inside the doorway to observe the resident smoke the DON stated, "I hate to say this but we don't have enough staff."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	F – 329 See F – 279 RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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F 329	Continued From page 19 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 1 of 10 residents (R50) reviewed for unnecessary medication use. Findings include: R50 routinely received an antidepressant medication and a supplement to help her sleep, without adequate assessment and monitoring for the efficacy of these medications. R50 was admitted to the facility 12/17/12 with diagnoses including: Alzheimer's disease, status post fall with resultant fractured ribs, and a history of depression and sleep disturbance secondary to Alzheimer's disease. Review of the physician's orders dated 12/20/12, indicated the resident had routine orders to use Celexa (an antidepressant) and Melatonin (a dietary supplement often used to help with sleep) on a daily basis.	F 329		

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F 329	Continued From page 20 Review of the record failed to indicate whether any monitoring had been initiated to determine a baseline for monitoring efficacy of these use of the medications. During interview with the assistant director of nursing on 1/4/13 at 12:05 p.m., she verified that the facility had not initiated any mood or behavior monitoring for the use of Celexa, nor had they completed a base line sleep study in order to determine the efficacy of the Melatonin usage.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356	F – 356 It is the intent of the Parker Oaks Communities Inc. to post daily nursing hours in accordance with federal and state regulation 483.30(e). The facility posted nursing shift hours will be updated on 2/7/13. Medical records or Nursing staff will be responsible for posting the Nursing Staff information. This will be audited by the Administrator on a weekly basis x2 weeks by Administrator walking rounds. Date Compliant: 2/7/13 RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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F 356	Continued From page 21 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required information for nursing hours on a daily basis at the beginning of each shift. This had the potential to affect 28 of 28 residents residing in the facility at the time of the survey and any members of the public that wished to view this information. Findings include: During the initial tour of the facility at 9:00 a.m. on 1/2/13, and during subsequent observations on 1/3 and 1/4/13, the facility failed to post the actual hours worked for licensed and unlicensed nursing staff responsible for resident care per shift. During an interview with the director of nursing (DON) at 1:05 p.m. on 1/4/13, the DON verified the staff posting failed to include the hours that comprised the shifts for the actual nursing hours worked. The DON stated, "Corporate just made us change that; our last form had it on there."	F 356		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside	F 411		

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F 411	Continued From page 22 resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist 2 of 3 residents (R32 and R30) in the sample who required dental services with arrangements for dental services to meet their needs. The findings include: R32 complained of tooth/mouth pain and the facility had not evaluated the need for a potential dental referral. During an interview with R32 at 7:30 p.m. on 1/3/12, R32 stated she had upper right tooth pain almost all of the time. R32 stated she had been using anbesol (an oral anesthetic) gel for comfort. However, R32 stated it was not relieving her pain anymore. The resident also stated she had recently called her friend to make a dental appointment for her, because the facility staff had not done so. Observations of the resident's mouth, at that time, revealed R32 have several chipped and darkened teeth in her mouth. R32 pointed to a tooth in her right upper gum area that	F 411	F – 411 The Parker Oaks Communities Inc. must provide dental services for all of its residents. In the instance of R32 and R30 and similar affected residents the A.D.O.N or designee will examine the resident's mouth to detect any oral health problems and document results on admission and quarterly assessment on dental health assessment form. The resident and or family will be asked by the facility social services designee on an annual basis whether they would like us to schedule an annual dental exam. All nursing staff members are required to attend an in-service session on 2/7/13 that will cover the following topic: review of Parker Oaks Communities Inc. oral health care protocol. Staff members who are unable to attend will be required to meet D.O.N or A.D.O.N to go over information on an individual basis. RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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F 411	Continued From page 23 was causing her pain. The area around that tooth appeared to be slightly reddened. Review of the resident's most current care plan dated 4/3/12, identified a problem of "Dental Pain." Approaches included: The resident has a dental visit on 4/2012. Review of notes from a dental appointment visit 4/4/12, identified the resident as having several teeth on the maxillary that 'hurt to tap on'. A cold check was within normal ranges of her dental exam. The note further questioned if possibly the resident was having problems with her maxillary sinus. The exam was unable to pinpoint any real problems. The dental notes further indicated that if the patient developed a continuous toothache or swelling the staff was to notify the dental clinic. Review of the most current oral assessment dated conducted between 12/14 and 12/20/12, identified the resident as having debris in her mouth prior to going to bed at night, broken, loose or carious teeth, inflamed gums, swollen gums, bleeding gums, oral abscesses, ulcers or rashes. The assessment also identified the resident as having mouth pain. During an interview with the director of nursing (DON) at 9:00 a.m. on 1/4/13, the DON verified there was no other information to specifically identify the areas of these concerns, nor interventions regarding the findings, on the assessment. Review of a nurse's note dated 10/19/12, stated R32 had complained of a toothache indicating it had hurt for 3 to 4 days. The note further indicated that a call was placed to the resident's	F 411	On a monthly basis x2, the D.O.N or designee will randomly audit at a 25% chart pull of resident records for completion of oral/dental health assessments, documentation of resident/family inquiry regarding desire for annual dental exam date complete 2/7/13. Results will be summarized at Quality Council Committee meetings and Quality Council will evaluate need for continued compliance monitoring. D.O.N is responsible for overall compliance of this regulation. Date Compliant: 2/7/13 RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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F 411	Continued From page 24 friend to make a dental appointment. Further review of the medical record revealed that as of yet, no dental appointment had been made. This was verified by interview with the DON at 1:00 p.m. on 1/4/13. A nurse's note entry dated 11/7/12, indicated R32's gums and tooth on the front upper right side were painful. The note further indicated the resident had difficulty swallowing medication, because she did not want the water she took to swallow the medication, to touch the painful areas in her mouth. No follow up documentation was found in the medical record regarding the resident's complaints from 11/7/12. A nurse's note dated 12/13/12, indicated R32's physician had advised her to use anbesol to treat the tooth pain. The physician's instructions were to see the dentist if the anbesol did not help her pain. A nurse's note dated 12/22/12, indicated R32 was having more tooth/mouth pain, that the anbesol gel was not helping the resident's pain, and that the facility staff would make a dental appointment. A subsequent nurse's communication note to the physician dated 12/26/12, indicated the resident's right upper gum and mouth hurt "very badly" and that she was having difficulty swallowing, chewing and talking. The nurse's note requested something stronger for R32's pain. The physician's response included an order for vicodin (a narcotic pain medication) as needed (PRN) for the resident's mouth pain. However, the dentist was not informed of R32's increased	F 411		

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F 411	Continued From page 25 mouth pain, nor was a referral made. Interview with the DON at 1:00 p.m. on 1/4/12, verified that the resident had continued complaints of mouth pain and that the dentist should have been notified when R32 was having increased mouth pain. R30 complained of tooth pain and the facility did not evaluate the need for a potential dental referral. R30 was admitted to the facility on 5/2/2008 with diagnoses including but not limited to Parkinson's disease and dementia. A quarterly minimum data set (MDS) dated 6/28/12, indicated, "Mouth or facial pain, discomfort, or difficulty with chewing." The care plan last reviewed 1/2/13 included: "Staff offer dental exams annually & PRN (as necessary)". During interview with R30 on 1/2/13 at 11:55 a.m., R30 reported tooth pain on the lower left side of her mouth. R30 stated she had been having the pain prior to the interview and had reported it to staff. She stated she was unsure how long ago the pain had started. During the course of the interview, licensed practical nurse (LPN)-Z entered R30's room to administer medication. R30 reported the dental pain to LPN-Z at that time. LPN-Z acknowledged R30's report of dental pain and indicated she would look into getting R30 some Tylenol. A nurse's note dated 12/14/12 indicated, "Resident c/o (complained of) tooth pain (arrow pointing up) (L (left)) side, call placed to dentist, they weren't open so message was left for Monday."	F 411		

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F 411	Continued From page 26 The pain monitoring flow sheets for December 2012 and January 2013, did not identify R30's complaints of pain from 12/14/12 or 1/02/13. The DON was interviewed on 1/7/13 at 10:19 a.m. The DON confirmed that a follow up dental appointment had not been made for R30. The DON also confirmed that R30's complaints of pain to the nurse on 1/2/13 should have been documented with a chart note, indicated on the pain monitoring flow sheet and followed up on. LPN-Z was interviewed again on 1/7/13 at 11: 05 a.m. LPN-Z confirmed that R30 had complained of tooth pain last week on 1/2/13. LPN-Z verified that she had left a message for R30's daughter on 1/7/13 to make a dental appointment for her mother but had not followed-up on the dental pain, nor contacted R30's daughter, about a potential dental appointment until that time.	F 411		

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

F5398021

PRINTED: 01/22/2013
FORM APPROVED
OMB NO. 0938-0391

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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, Parker Oaks 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	POC ok 2-5-13 RECEIVED FEB - 4 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION RECEIVED FEB 04 2013 Minnesota Dept of Health Mankato	

DC: 2-16-13

EXIT: 1-7-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin | (X6) DATE: 2-1-13

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

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	245398	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Parker Oaks Communities Inc. is a 3-story building with full basement. The building was constructed in 1965 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 29 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 011 SS=F	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 observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 19.1.1.4.1 and 8.2.3.2. The deficient practice could affect all 29 residents. Findings include: On facility tour between 8:50 AM and 11:30 AM on 01/03/2012, observation revealed that the 2 hour fire rated building separation wall between the nursing home and the assisted living building the double doors do not shut and positively latch. This deficient practice was confirmed by the Facility Maintenance Director (AN) at the time of discovery.	K 011	K – 11 Parker Oaks Communities Inc. will have the door between the nursing home and assisted living fixed on 2/7/13. A call has been placed for parts and service on 1/11/13 and 1/29/13. All fire doors in the facility are checked per monthly fire drill. Audits will be conducted on every fire drill for 3 months to ensure compliance. Date Corrected: 2/7/13	
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	K 025		

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

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K 025	Continued From page 3 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, the facility failed to maintain smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, 8.3.2 and 8.3.6. The deficient practice could affect 15 out of 30 residents. Findings include: On facility tour between 8:50 AM and 11:30 AM on 01/03/2012, observation revealed that the smoke barrier by room C305 has an open penetration around a 3/4 inch conduit and cables above smoke barrier doors above the lay in ceiling. NOTE: All smoke barriers need to be checked from exterior wall to exterior wall. This deficient practice was confirmed by the Facility Maintenance Director (AN) at the time of discovery.	K 025	K – 25 Parker Oaks Communities Inc. Chief Building Engineer has sealed the open penetration by room C305 and 2nd floor soiled linen room around 3 inch sewer line. All floors of the facility have been checked for any open penetrations and if found have been sealed per code completed on 1/15/13. Date Corrected: 1/15/13 RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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K 029	Continued From page 4 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 observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out of 29 residents. Findings include: On facility tour between 8:50 AM and 11:30 AM on 01/03/2012, observation revealed that the following were found: 1. Basement - Walmart storage room over 50 square feet, does not have an automatic door closer 2. Basement - maintenance storage room next to linen storage over 50 square feet, does not have an automatic door closer 3. 2nd floor - soiled linen room has open penetrations around 3 inch sewer line.	K 029	K – 29 Parker Oaks Communities Inc. Chief Building Engineer has replaced the hinges on walmart storage door and maintenance storage door on 1/23/13 to ensure proper self closing. The self closing hinged doors in the facility have been added to the facilities PM program. Random audits of self closing doors will be audited for one month and then per PM program. Date Compliant: 1/23/13 RECEIVED FEB 0 6 2013 Minnesota Dept of Health Mankato	

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K 029	Continued From page 5 These deficient practices were confirmed by the Facility Maintenance Director (AN) at the time of discovery.	K 029		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-2.1.1 and 2-2.2. This deficient practice could affect all 15 out 29 residents. Findings include: On facility tour between 8:50 AM and 11:30 AM on 01/03/2012, observation revealed that the following were found: 1. Basement - laundry room, the fire sprinkler head located behind the dryers was corroded 2. Basement - Mechanical room, half of the sheetrock ceiling was missing. This would cause the delay in the fire sprinklers located in this room to have slow activation.	K 062	K – 62 Parker Oaks communities Inc. Chief Building engineer has removed the ½ inch rubber tube attached to the fire sprinkler line on 1/8/13. The sheetrock in the Mechanical room in the basement will be installed when First Choice Security is finished replacing the fire panel. They will need to run wires above the sheetrock ceiling. The ceiling will be replaced with 5/8 inch. sheetrock and fire proof caulk. The new fire panel is to be completed on 2/1/13 with the sheetrock ceiling being complete by 2/7/13. The fire sprinkler head located behind the dryers was replaced on 1/30/13 by Olympic Fire Protection. Date Completed: 2/7/13 RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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K 062	Continued From page 6 3. 1st floor - nursing station, there is a 1/2 inch rubber tube attached to the fire sprinkler line These deficient practices were confirmed by the Facility Maintenance Director (AN) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9127

January 22, 2013

Ms. Dorothy Baker, Administrator
Parker Oaks Communities Inc
211 6th Street Northwest
Winnebago, MN 56098

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5398024

Dear Ms. Baker:

The above facility was surveyed on January 2, 2013 through January 7, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Park Place 12 Civic Center Plaza Suite 2105 Mankato Minnesota 56001. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Maria King at (507) 344-2716.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00120	A. BUILDING _____ B. WING _____	01/07/2013

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 2, 3, 4 and 7th, 2013 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: 2-1-13

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2 000	Continued From page 1 Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:	2 265		

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2 265	Continued From page 2 A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to notify the physician when a resident experienced abnormal bleeding from the gastrointestinal tract for 1 of 3 resident (R39) reviewed for hospitalization. The findings include: R39 was admitted to the facility with anemia (low iron levels in the blood-identified by laboratory values of low hemeglobin and hematocrit). The resident subsequently experienced blood in his feces during bowel movements. The physician was not notified of this change in the resident's condition.	2 265		

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2 265	Continued From page 3 R39 was admitted to the facility from the hospital on 12/4/12, following repair of a fractured left hip. Review of medical record documents provided to the facility from the hospital, revealed R39 had a low hemoglobin and hematocrit upon admission to the nursing home. The hospital records indicated R39 had a hemoglobin of 13.3 (normal value would be 13.5 to 17.5 for males) on the day of admission to the hospital 11/26/12. However, further review of the hospital records indicated R39's hemoglobin values dropped and continued to be below the normal reference range during his stay at the hospital. Documented lab values included a hemoglobin of 11.8 and a hematocrit of 35.6 (normal reference value 38.8 to 50) on 11/27/12; hemoglobin of 8.8 and hematocrit of 27.7 on 11/28/12; hemoglobin of 9.7 and hematocrit of 29.7 on 11/29/12; hemoglobin of 8.4 and hematocrit of 27 on 11/30/12; hemoglobin of 8.1 and hematocrit of 24.8 on 12/2/12; and on 12/4/12, the day of the resident's admission to the nursing home, documents indicated the resident's hemoglobin was 7.7 and hematocrit was 23.6. The hospital record documents also indicated R39 upheld Jehovah Witness religious beliefs and had refused blood products to treat the anemia. However, review of the hospital reports confirmed R39 had received an oral iron supplement while hospitalized. R39 had received ferrous sulfate 324 mg (milligrams) twice a day on 11/28/12, 11/ 29/12, 11/30/12 and 12/1/12. The medication had then been switched to Niferex 150 mg daily and the resident had received that medication on 12/2/12 and 12/3/12. Review of the nursing home record revealed R39 received no iron supplementation following admission to the nursing home. In addition, there was no documentation the facility had contacted the physician regarding the use of any iron	2 265		

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2 265	Continued From page 4 supplements for R39 while at the nursing home. Review of the nursing home nurses notes revealed an entry dated 12/5/12, "to commode for BM [bowel movement]. Passed an almost black moderate BM with dark red blood passed also, less than 30 cc [cubic centimeters]." There was no documentation in the medical record demonstrating the physician had been made aware of R39's dark and bloody stool. On 12/8/12, there was again documentation of a dark bloody stool, "up to commode per stand-up lift for BM [bowel movement]. Passed a large stool with blood accompanying it." Again, there was no documentation the facility notified the physician of the bloody stool. On 12/16/12, the nurses' notes revealed R39 had a fever of 103.3 degrees Fahrenheit (F) at the time of his morning cares and was unable to follow directions. The next entry in the notes was at 4:00 p.m. when the nurse documented, "Resident up in bed denies pain at this point in time. Shows signs of decreased level of consciousness, temp. 100.8, skin warm, dry and pale in color. BP [blood pressure] 78/55, shows no signs of anxiety or respiratory distress, oxygenation 92% at 2 liters per minute. Respirations 16, consumed 10% of dinner. Sent to ER [emergency room] to treat and evaluate." The resident had not returned to the facility. When interviewed on 1/4/13, at 2:15 p.m. the director of nursing (DON) stated the resident had been transferred to the hospital and had died there. When asked about R39's low hemoglobin and hematocrit at the time of his admission, the DON acknowledged that when staff had noticed no iron supplement was ordered, she would have expected the nursing staff to call the physician to	2 265		

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2 265	Continued From page 5 clarify whether iron supplementation should be provided to the resident. The DON also added that she'd been unaware R39 had experienced dark and bloody stools while at the facility. She stated she would have expected the nurses to call the physician to report the abnormal stools. The facility's policy and procedure, Physician Communication Policy and Procedure, included; "It is the policy of Parker Oaks Communities to communicate changes in residents' condition to the MD in a timely manner, so that the highest quality of care possible can be delivered. It is the responsibility of the licensed charge nurse to give notification of resident status." Situations listed in the policy as to when the physician would be telephoned included abnormal bleeding. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise the policies and procedures regarding notification of the physician. All staff involved with notifying the physician of resident changes could be educated regarding the procedure. The quality assurance committee could randomly audit records to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed	2 555	RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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2 555	Continued From page 6 by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to develop a comprehensive care plan for 1 of 10 residents (R26) in the sample reviewed for unnecessary medication use. Findings include: R26 did not have a comprehensive care plan developed within 21 days of admission. R26 was admitted to the facility on 11/28/12 with diagnoses including: dementia, panic attacks, hypothyroidism, chronic anemia, anxiety, cardiomegaly, hypercholesterolemia, hypertension and depression. Medical record review for medication usage indicated R26 received medications including Lasix (a diuretic), Lisinopril and Metoprolol (antihypertensives), Levothyroxine (thyroid medication), Latvian (anti-anxiety), Zoloft and Trazadone (antidepressants) and Fergon (iron). During additional review of the record to determine whether there were adequate indications for use, or regular monitoring for efficacy/side effects, it was noted there was had been no comprehensive care plan developed for the resident. Only a 'daily needs/functional care plan,' a check list of ADL's (activities of daily	2 555		

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2 555	Continued From page 7 living), communication, hearing, vision, cognition and behavioral symptoms was available in the medical record. No comprehensive care plan had been developed to determine interventions for the resident's care. The director of nursing was interviewed on 1/3/13 at 6:35 p.m. She verified there had been no comprehensive care plan developed for R26 since admission admission 34 days prior. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could provide education for the licensed staff regarding the importance of developing individualized plans of care in a timely manner to meet the needs of residents. The Director of Nursing could randomly audit resident charts to ensure the plans of care were completed appropriately. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 555		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830	RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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2 830	Continued From page 8 This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to seek medical direction and/or treatment for abnormal bleeding from the gastrointestinal (GI) tract for 1 of 3 resident (R39) reviewed for hospitalization. These factors resulted in harm for R39, who required hospitalization for this issue and later died. In addition, the facility failed to recognize and treat pain related to a dental condition for 1 of 3 residents (R30) reviewed for dental services. The findings include: R39 was admitted to the facility with anemia (low iron levels in the blood-identified by laboratory values of low hemeglobin and hematocrit). The resident subsequently experienced blood in his feces during bowel movements. The facility did not seek direction or treatment for this condition. R39 was admitted to the facility from the hospital on 12/4/12, following repair of a fractured left hip. Review of medical record documents provided to the facility from the hospital, revealed R39 had a low hemoglobin and hematocrit upon admission to the nursing home. The hospital records indicated R39 had a hemoglobin of 13.3 (normal value would be 13.5 to 17.5 for males) on the day of admission to the hospital 11/26/12. However, further review of the hospital records indicated R39's hemoglobin values dropped and continued to be below the normal reference range during his stay at the hospital. Documented lab values included a hemoglobin of 11.8 and a hematocrit of 35.6 (normal reference value 38.8 to 50) on 11/27/12; hemoglobin of 8.8 and hematocrit of 27.7 on 11/28/12; hemoglobin of 9.7 and hematocrit of 29.7 on 11/29/12; hemoglobin of	2 830		

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2 830	Continued From page 9 8.4 and hematocrit of 27 on 11/30/12; hemoglobin of 8.1 and hematocrit of 24.8 on 12/2/12; and on 12/4/12, the day of the resident's admission to the nursing home, documents indicated the resident's hemoglobin was 7.7 and hematocrit was 23.6. The hospital record documents also indicated R39 upheld Jehovah Witness religious beliefs and had refused blood products to treat the anemia. However, review of the hospital reports confirmed R39 had received an oral iron supplement while hospitalized. R39 had received ferrous sulfate 324 mg (milligrams) twice a day on 11/28/12, 11/ 29/12, 11/30/12 and 12/1/12. The medication had then been switched to Niferex 150 mg daily and the resident had received that medication on 12/2/12 and 12/3/12. Review of the nursing home record revealed R39 received no iron supplementation following admission to the nursing home. In addition, there was no documentation the facility had contacted the physician regarding the use of any iron supplements for R39 while at the nursing home. Review of the nursing home nurses notes revealed an entry dated 12/5/12, "to commode for BM [bowel movement]. Passed an almost black moderate BM with dark red blood passed also, less than 30 cc [cubic centimeters]." There was no documentation in the medical record demonstrating the physician had been made aware of R39's dark and bloody stool. On 12/8/12, there was again documentation of a dark bloody stool, "up to commode per stand-up lift for BM [bowel movement]. Passed a large stool with blood accompanying it." Again, there was no documentation the facility notified the physician of the bloody stool. On 12/16/12, the nurses' notes revealed R39 had	2 830		

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2 830	Continued From page 10 a fever of 103.3 degrees Fahrenheit (F) at the time of his morning cares and was unable to follow directions. The next entry in the notes was at 4:00 p.m. when the nurse documented, "Resident up in bed denies pain at this point in time. Shows signs of decreased level of consciousness, temp. 100.8, skin warm, dry and pale in color. BP [blood pressure] 78/55, shows no signs of anxiety or respiratory distress, oxygenation 92% at 2 liters per minute. Respirations 16, consumed 10% of dinner. Sent to ER [emergency room] to treat and evaluate." The resident had not returned to the facility. When interviewed on 1/4/13, at 2:15 p.m. the director of nursing (DON) stated the resident had been transferred to the hospital and had died there. When asked about R39's low hemoglobin and hematocrit at the time of his admission, the DON acknowledged that when staff had noticed no iron supplement was ordered, she would have expected the nursing staff to call the physician to clarify whether iron supplementation should be provided to the resident. The DON also added that she'd been unaware R39 had experienced dark and bloody stools while at the facility. She stated she would have expected the nurses to call the physician to report the abnormal stools. The facility's policy and procedure, Physician Communication Policy and Procedure, included; "It is the policy of Parker Oaks Communities to communicate changes in residents' condition to the MD in a timely manner, so that the highest quality of care possible can be delivered. It is the responsibility of the licensed charge nurse to give notification of resident status." Situations listed in the policy as to when the physician would be telephoned included abnormal bleeding.	2 830		

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2 830	Continued From page 11 The facility failed to evaluate and monitor R30's complaints of tooth pain. R30 was admitted to the facility on 5/2/08 with diagnoses including but not limited to Parkinson's disease and dementia. The quarterly minimum data set (MDS) dated 6/28/12 identified the resident experienced, "Mouth or facial pain, discomfort, or difficulty with chewing". Interventions on R30's plan of care, last reviewed 1/2/13, included: "Staff offer dental exams annually & PRN (as needed)". During an interview with R30 on 1/2/13 at 11:55 a.m., R30 reported she'd experienced tooth pain on the lower left (L) side of her mouth. R30 stated she had been having the pain prior to the interview and had reported it to staff, however was unsure how long ago the pain had initially started. During the course of the interview, licensed practical nurse (LPN)-Z entered R30's room to administer medication. R30 reported the dental pain to LPN-Z at that time. LPN-Z acknowledged R30's report of dental pain and indicated she would look into getting R30 some Tylenol. The resident's record was reviewed. An interdisciplinary note dated 12/14/12 included: "Resident c/o (complained of) tooth pain (arrow pointing up) (L) side, call placed to dentist, they weren't open so message was left for Monday." The pain monitoring flow sheets for December 2012, and January 2013, included no record of the resident's complaints of pain from 12/14/12, or 1/02/13. When interviewed on 1/7/13 at 10:19 a.m., the director of nursing (DON) confirmed that R30's	2 830		

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2 830	Continued From page 12 complaints of pain to the nurse on 1/2/13 should have been documented with a chart note, and on the pain monitoring flow sheet, and that there should have been follow up with the resident. When interviewed on 1/7/13 at 11: 05 a.m., LPN-Z confirmed that R30 had complained of tooth pain last week on 1/2/13. LPN-Z verified that she had not followed-up on the dental pain, nor attempts to contact R30's daughter about a potential dental appointment, until just that morning (1/7/13). Also, based on observation, interview and document review the facility failed to provide adequate supervision in order to prevent accidents for 1 of 3 residents in the sample (R7) who was identified as being potentially unsafe with smoking. Findings include: R7 was observed to have what appeared to be cigarette burn holes in her clothing. Although facility staff acknowledged the resident's potential for unsafe smoking, they had not implemented supervision of her smoking to prevent accidents. R7 was admitted to the facility 8/24/11 with diagnosis including chronic tobacco abuse, chronic obstructive pulmonary disease, dementia and anxiety. During interview and observation of R7 on 1/2/13, at 11:16 a.m. it was noted that she had numerous cigarette burn holes in her slacks. When asked what had happened, she stated she didn't know how the holes got there and also stated that her son told her he was going to take her cigarettes away from her because of the holes. R7 was	2 830		

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2 830	Continued From page 13 noted to have a pack of cigarettes and a lighter in her pocket. During additional observations on 1/3/13 and 1/4/13, R7 was noted to have small holes in the slacks she was wearing. R7's record was reviewed. The quarterly Minimum Data Set (MDS) dated 8/30/12, indicated a BIMS (Brief Interview for Mental Status) score of 6 which indicated the resident had severe cognitive impairment. A subsequent quarterly MDS dated 11/29/12, indicated a BIMS score of 00 which also indicated severe cognitive impairment. An initial smoking evaluation dated 8/24/11, indicated R7 was alert and oriented to person, place and time, does not want to quit smoking, had been informed of the facility's smoking policy, followed the facility smoking policy (smokes in designated areas, follows schedule, does not smoke when oxygen is present etc.), can safely utilize the lighter/matches and light smoking material, does not use a smoking apron and demonstrates safe smoking practices with other residents. The evaluation identified R7 as being independent. An updated smoking assessment dated 9/25/12, indicated: "Other: Burning holes in clothing - must now wear smoking apron when she goes outside." A nurse's note from 9/25/12 included, "As a result of unsafe smoking practices, resident has been instructed and educated on proper use of smoking apron and why it is needed to maintain her safety. Resident is AAO x 3 (alert and orientated to person, place and time) and states she wishes to continue smoking. She verbalized that she understands why she needs to wear the apron. Staff will monitor that she wears the apron and continue to provide ongoing education to resident." A nurse's note dated 9/28/12, indicated the resident had	2 830		

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2 830	Continued From page 14 occasionally been non-compliant with the use of the smoking apron. The note further indicated staff had explained the risks of not using the apron to R7, and that she had indicated she knew this and "doesn't care." Staff was to continue to provide encouragement to the resident to utilize the smoking apron. According to a nursing note from 10/17/12, the resident had been observed outside smoking without the smoking apron. Staff had provided education and indicated they would continue to monitor. The resident's care plan was updated 9/25/12 to include: "Risk for injury R/T (related to) unsafe smoking practices and occasional non-compliance with wearing smoking apron." The approaches included, "Ongoing education will be provided by staff regarding safe smoking practices. Staff will encourage resident to wear smoking apron every time she goes outside to smoke." The facility's SMOKING EVALUATION POLICY AND PROCEDURE dated 5/14/08 included: "PURPOSE: It is the decision of the facility how, when and where to allow smoking and a decision by the resident to smoke. However, residents need to smoke safely and this assessment may assist the facility in making this decision. POLICY: It is the policy that all residents who want to smoke are evaluated and assessed for smoking safety. PROCEDURE: 1. The assessment is to be used at the time of admission and PRN (as needed). 2. The smoking evaluation form will be completed by the charge nurse, case manager or MDS nurse. 3. Form is used to gather information ...when there is a concern over the resident's behavior and safety smoking. 4. Include the resident and responsible party as indicated."	2 830		

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2 830	Continued From page 15 R7 was observed on 1/4/13 at 11:20 a.m., to be in her room counting her cigarettes. When questioned by the surveyor at that time, the resident stated she goes outside "a lot." During an interview with the director of nursing (DON) on 1/4/13 at 11:15 A.M., she stated the resident goes out to smoke whenever she wants to. She stated that the resident and family had risks and benefits of unsafe smoking explained to them and that R7 "does what she wants and won't let us help her at all." When the DON was asked about the resident keeping cigarettes and lighters on her person the DON responded, "I don't know about that, we have a smoking policy" and shrugged her shoulders. On 1/4/13 at 1:30 p.m., R7 was observed going to the smoking area. This smoking area was located outside on the backside of the facility. The area was not near the nursing facility but by the attached assisted living. R7 did not have the smoking apron on. She was observed to light and smoke the entire cigarette without dropping any ashes in her lap. During this observation, there were no staff present in the area to supervise. Licensed practical nurse (LPN)-A was interviewed on 1/4/13 at 1:30 p.m. LPN-A verified that R7 goes out to smoke a lot, "especially when she's bored." When asked whether anyone watches R7 while she smokes, LPN-A stated, "oh no, she goes by herself." When asked if R7 wears the smoking apron, LPN-A stated that R7 was supposed to wear the apron but often refuses. "If we put it on her she rips it off." During interview with the administrator on 1/4/13 at 1:45 p.m., the administrator stated the facility	2 830		

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2 830	Continued From page 16 was currently using the policy from May of 2008, but that they would be implementing a new smoking policy going forward. During an additional interview with the DON on 1/4/13 at 1:55 p.m., the DON verified that R7 may not be safe to smoke independently as evidenced by the holes in her clothing. She stated that the resident does not allow staff to sit with her while she smokes because she is "embarrassed by that." When asked if they could stand inside the doorway to observe the resident smoke the DON stated, "I hate to say this but we don't have enough staff." SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and re-educate staff on policies to ensure that all residents are assessed and provided necessary supervision, care and services. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to	2 895	RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	

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2 895	Continued From page 17 increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received range of motion services to maintain function for 1 of 3 residents (R27) reviewed in the sample for range of motion. Findings include: R27 had limited range of motion (ROM) in his upper extremities and the facility did not provide ROM services. During an observation of R27 on 1/3/12 at 5:25 p.m., the resident was observed to have a wrist and knuckle contractures on the left hand. The resident was not observed to utilize a splint. R27's diagnoses included generalized weakness and history of a cerebral vascular accident (CVA) with left sided hemiparesis. The quarterly minimum data set (MDS) dated 11/8/12, identified R27 as requiring extensive assistance for most activities of daily living (ADL's). In addition, R27 was identified with functional limitations of one side, for both upper and lower extremities. Review of the plan of care dated 5/16/12, identified the resident as having an alteration in ADL's related to generalized weakness, activity intolerance secondary to a history of a CVA, with left sided hemiparesis and significant right sided weakness. The care plan indicated the resident	2 895		

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2 895	Continued From page 18 required extensive assistance with all ADL's. Review of the "Restorative Care Program" notes dated 5/22/12, included a program to maintain R27's functional motion in the upper extremities. The program included directions for passive range of motion to both arms 3 times weekly; and to provide movement in both arms, one at a time, gently forwards, inwards, backwards and to the sides 5 times each. This program had been recommended by the Occupational Therapist when formal therapy services had been discontinued. Although observations were made throughout the survey 1/2, 1/3 and 1/4/13, R27 was not observed to receive any restorative exercises. During interview with registered nurse (RN)-A at 6:35 p.m. on 1/3/12, she stated she thought the facility therapy department provided restorative services for the resident, but was unsure. During interview with nursing assistant (NA)-A at 6: 45 p.m. on 1/3/12, she stated she was unaware of who was responsible for providing restorative nursing for R27. She further confirmed she had never observed the services being provided. During interview with the director of nursing (DON) at 7:00 p.m. on 1/3/12, she indicated the nursing assistants were responsible for providing restorative services for R27. When questioned about which days the resident was supposed to be receive such exercises, the DON was unable to provide that information. The DON further confirmed that R27's ROM program may not be getting done because there had been no days or times designated for the staff to provide the	2 895		

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2 895	Continued From page 19 services. During interview with licensed practical nurse (LPN)-B at 7:15 p.m. on 1/3/12, she stated she thought the licensed staff provided R27's ROM services and that it would be noted on the resident's treatment sheet. However, when LPN-B reviewed R27's treatment sheet with the surveyor, she confirmed the treatment sheets did not indicate that any services were being provided by the licensed staff. LPN-B also confirmed she had not been providing these services for R27. During interview with NA-B at 7:52 a.m. on 1/4/12, she stated she works routinely with R27 and has never provided the ROM exercises. She verified she had been unaware of the recommendations. During interview with NA-C at 8:00 a.m. on 1/4/12, she stated she was unaware of who was responsible for providing ROM to residents and confirmed that she had never provided ROM for R27. During interview with the facility's Occupational Therapist at 10:00 a.m. on 1/4/12, she confirmed R27 had impairments of the upper extremities and that the facility staff should be following her recommendations for restorative nursing to maintain the resident's functional motion. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise policies and procedures for range of motion programs, could educate the appropriate personnel in any changes, and could appoint a designee to monitor for ongoing compliance.	2 895		

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2 895	Continued From page 20 TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 895		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist 2 of 3 residents (R32 and R30) in the sample who required dental services with arrangements for dental services to meet their needs. The findings include: R32 complained of tooth/mouth pain and the facility had not evaluated the need for a potential dental referral. During an interview with R32 at 7:30 p.m. on 1/3/12, R32 stated she had upper right tooth pain almost all of the time. R32 stated she had been using anbesol (an oral anesthetic) gel for comfort. However, R32 stated it was not relieving her pain anymore. The resident also stated she had recently called her friend to make a dental appointment for her, because the facility staff had	21325		

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,21325	Continued From page 21 not done so. Observations of the resident's mouth, at that time, revealed R32 have several chipped and darkened teeth in her mouth. R32 pointed to a tooth in her right upper gum area that was causing her pain. The area around that tooth appeared to be slightly reddened. Review of the resident's most current care plan dated 4/3/12, identified a problem of "Dental Pain." Approaches included: The resident has a dental visit on 4/2012. Review of notes from a dental appointment visit 4/4/12, identified the resident as having several teeth on the maxillary that 'hurt to tap on'. A cold check was within normal ranges of her dental exam. The note further questioned if possibly the resident was having problems with her maxillary sinus. The exam was unable to pinpoint any real problems. The dental notes further indicated that if the patient developed a continuous toothache or swelling the staff was to notify the dental clinic. Review of the most current oral assessment dated conducted between 12/14 and 12/20/12, identified the resident as having debris in her mouth prior to going to bed at night, broken, loose or carious teeth, inflamed gums, swollen gums, bleeding gums, oral abscesses, ulcers or rashes. The assessment also identified the resident as having mouth pain. During an interview with the director of nursing (DON) at 9:00 a.m. on 1/4/13, the DON verified there was no other information to specifically identify the areas of these concerns, nor interventions regarding the findings, on the assessment. Review of a nurse's note dated 10/19/12, stated R32 had complained of a toothache indicating it	21325		

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21325	Continued From page 22 had hurt for 3 to 4 days. The note further indicated that a call was placed to the resident's friend to make a dental appointment. Further review of the medical record revealed that as of yet, no dental appointment had been made. This was verified by interview with the DON at 1:00 p.m. on 1/4/13. A nurse's note entry dated 11/7/12, indicated R32's gums and tooth on the front upper right side were painful. The note further indicated the resident had difficulty swallowing medication, because she did not want the water she took to swallow the medication, to touch the painful areas in her mouth. No follow up documentation was found in the medical record regarding the resident's complaints from 11/7/12. A nurse's note dated 12/13/12, indicated R32's physician had advised her to use anbesol to treat the tooth pain. The physician's instructions were to see the dentist if the anbesol did not help her pain. A nurse's note dated 12/22/12, indicated R32 was having more tooth/mouth pain, that the anbesol gel was not helping the resident's pain, and that the facility staff would make a dental appointment. A subsequent nurse's communication note to the physician dated 12/26/12, indicated the resident's right upper gum and mouth hurt "very badly" and that she was having difficulty swallowing, chewing and talking. The nurse's note requested something stronger for R32's pain. The physician's response included an order for vicodin (a narcotic pain medication) as needed (PRN) for the resident's mouth pain. However, the dentist was not informed of R32's increased	21325		

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21325	Continued From page 23 mouth pain, nor was a referral made. Interview with the DON at 1:00 p.m. on 1/4/12, verified that the resident had continued complaints of mouth pain and that the dentist should have been notified when R32 was having increased mouth pain. R30 complained of tooth pain and the facility did not evaluate the need for a potential dental referral. R30 was admitted to the facility on 5/2/2008 with diagnoses including but not limited to Parkinson's disease and dementia. A quarterly minimum data set (MDS) dated 6/28/12, indicated, "Mouth or facial pain, discomfort, or difficulty with chewing." The care plan last reviewed 1/2/13 included: "Staff offer dental exams annually & PRN (as necessary)". During interview with R30 on 1/2/13 at 11:55 a.m., R30 reported tooth pain on the lower left side of her mouth. R30 stated she had been having the pain prior to the interview and had reported it to staff. She stated she was unsure how long ago the pain had started. During the course of the interview, licensed practical nurse (LPN)-Z entered R30's room to administer medication. R30 reported the dental pain to LPN-Z at that time. LPN-Z acknowledged R30's report of dental pain and indicated she would look into getting R30 some Tylenol. A nurse's note dated 12/14/12 indicated, "Resident c/o (complained of) tooth pain (arrow pointing up) (L (left)) side, call placed to dentist, they weren't open so message was left for Monday."	21325		

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21325	Continued From page 24 The pain monitoring flow sheets for December 2012 and January 2013, did not identify R30's complaints of pain from 12/14/12 or 1/02/13. The DON was interviewed on 1/7/13 at 10:19 a.m. The DON confirmed that a follow up dental appointment had not been made for R30. The DON also confirmed that R30's complaints of pain to the nurse on 1/2/13 should have been documented with a chart note, indicated on the pain monitoring flow sheet and followed up on. LPN-Z was interviewed again on 1/7/13 at 11: 05 a.m. LPN-Z confirmed that R30 had complained of tooth pain last week on 1/2/13. LPN-Z verified that she had left a message for R30's daughter on 1/7/13 to make a dental appointment for her mother but had not followed-up on the dental pain, nor contacted R30's daughter, about a potential dental appointment until that time. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review the policies and procedures regarding the acquisition of dental services for residents. Routine audits of resident's oral status could be conducted to ensure dental services were offered if indicated. The Director of Nursing could provide training for all personnel to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21325		
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee	21415		

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21415	Continued From page 25 Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious.	21415		

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21415	Continued From page 26 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure new employees received a two-step tuberculin (TB) skin test (TST) for 4 of 5 new employees (E1, E2, E3 and E4) reviewed whose work involved direct contact with residents. Findings include: E1, was hired 3/28/12 and had not received a second step TST until 10/15/12. E2, was hired 4/19/12 and had not received a second step TST until 11/2/12. E3, was hired 5/20/12 and had not received a second step TST until 10/26/12. E4, was hired 6/21/12. E4 was a rehire who had a two step TST done 6/5/09. E4 did not have a new TST upon rehire. The facility's policy entitled, USE OF TUBERCULIN SKIN TEST (TST) FOR DIAGNOSING M. TUBERCULOSIS INFECTION IN HCW'S which was not dated, included: "if no previous TST result, a two-step baseline TST is required. If a previous negative TST result was over 12 months before new employment a two-step baseline TST will be done." During interview with the office manager/human	21415		

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21415	Continued From page 27 resource director on 1/4/13 at 10:00 a.m., she verifed that the two step TST's were not done upon hire and she did not know why. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure TB policies and procedures were developed and implemented to ensure completion of the two step mantoux for all newly hired employees. A quality assurance system could be developed to audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21415		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		

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21540	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 1 of 10 residents (R50) reviewed for unnecessary medication use. Findings include: R50 routinely received an antidepressant medication and a supplement to help her sleep, without adequate assessment and monitoring for the efficacy of these medications. R50 was admitted to the facility 12/17/12 with diagnoses including: Alzheimer's disease, status post fall with resultant fractured ribs, and a history of depression and sleep disturbance secondary to Alzheimer's disease. Review of the physician's orders dated 12/20/12, indicated the resident had routine orders to use Celexa (an antidepressant) and Melatonin (a dietary supplement often used to help with sleep) on a daily basis. Review of the record failed to indicate whether any monitoring had been initiated to determine a baseline for monitoring efficacy of these use of the medications. During interview with the assistant director of nursing on 1/4/13 at 12:05 p.m., she verified that the facility had not initiated any mood or behavior monitoring for the use of Celexa, nor had they completed a base line sleep study in order to determine the efficacy of the Melatonin usage.	21540		

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21540	Continued From page 29 SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the need for medication monitoring with the licensed staff including the State and Federal regulations. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards, and to ensure medications were monitored for potential adverse effects and efficacy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		