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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: V7WS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00449

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **35** (L18)
13.Total Certified Beds **35** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 11/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/07/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245592

December 29, 2016

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

Dear Ms.. Erickson:

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

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

Effective November 1, 2016 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 eNotice.

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 21, 2016

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

RE: Project Number S5592025

Dear Ms. Erickson:

On September 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 22, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On November 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2016, effective November 1, 2016 and therefore remedies outlined in our letter to you dated September 30, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245592 Y1	A. Building B. Wing Y2	11/10/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0167	Correction	ID Prefix F0334	Correction	ID Prefix F0431	Correction
Reg. # 483.10(g)(1)	Completed	Reg. # 483.25(n)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	11/01/2016	LSC	11/01/2016	LSC	10/21/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/21/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	LB/mm	11/21/2016	28035	11/10/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/22/2016

[ ] 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245592 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	10/13/2016 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0051	Correction Completed 10/11/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 10/10/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) TL/mm	DATE 11/21/2016	SIGNATURE OF SURVEYOR 36536	DATE 10/13/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/22/2016	☐ 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: V7WS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00449

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **35** (L18)
13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 10/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/07/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/07/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 30, 2016

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

RE: Project Number S5592025

Dear Ms. Erickson:

On September 22, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 1, 2016, 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 November 1, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 22, 2016 (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 March 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	09/22/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the most recent health survey results including the Life Safety code Results from the State Agency's survey conducted 7/23/2015. This deficient practice had the potential to affect all 31 residents in the facility.	F 167	1. Life Safety code Survey results were added to the posted survey results on 9/21/16. 2. All residents have the potential to be affected by the availability of Life Safety Code Survey results. 3. The Administrator or designee will be responsible for posting the state survey	11/1/16

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

Electronically Signed | 10/10/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING _____ B. WING _____	09/22/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 1 Findings include: On 9/19/16, at 2:00 p.m. during the initial tour of the facility, a bookshelf located across from the main nurses station was observed to contain a white three ring binder. The binder contained the results of the survey conducted on 7/23/15, however, it did not include the Life Safety Code survey results. On a subsequent check on 9/20/16, at 8:38 a.m. the binder continued to lack the Life Safety Code survey results. On 9/21/16, at 7:56 a.m. the administrator reviewed the white binder and verified the Life Safety Code survey was not included in the posted information, as required, for the residents, staff and general public. On 9/21/16, at 8:05 a.m. the administrator added the Life Safety Code survey from 7/23/16, to the posted survey results. The Posting of State Survey Results policy dated 9/2016, directed the administrator to post the Minnesota Department of Health and Life Safety Survey results with the plan of correction as soon as the results are available. The results are to be posted in a public space for access to the residents and the public.	F 167	results, both health survey and Life Safety Code survey, as soon as the POC is approved. 4. The posting of Life Safety Code results will be audited on a weekly basis x3 weeks and monthly x3 months by the Administrator or designee.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334		11/1/16

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F 334	Continued From page 2 that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal	F 334		

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F 334	Continued From page 3 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R36, R47, R45) had received the appropriate pneumococcal vaccination as directed the Centers for Disease Control. In addition the facilty failed to provided 1 of 5 resident (R45) with a influenza vaccinations. Findings include: The Centers for Disease Control (CDC)	F 334	1. R36 received the 2nd dose of PPSV23 on 1/29/2016. PCV13 will be administered on February 1st, 2017 per recommendations of CDC guidelines for immunization. R47 was discharged before PVC13 was offered. R45 was offered both PCV13 and PPSV23 on 10/4/2016; both immunizations were declined even after education of risks/benefits of vaccine. 2. All new and current resident records have been reviewed for their pneumococcal status. 3. & 4. Pneumococcal policy & procedure have	

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F 334	Continued From page 4 "Pneumococcal Vaccination Timing for Adults" algorithm dated 11/30/2015. The pneumococcal conjugate vaccine (PCV13) protects against 13 types of pneumococcal bacteria. PCV13 is recommended for all adults 65 years or older. The pneumococcal polysaccharide vaccine (PPSV23) protects 23 types of pneumococcal bacteria. It is recommended for all adults 65 years or older. PPSV23 is also recommended for adults 19-64 years old who smoke cigarettes or who have asthma. R36 was admitted to the facility on 2/9/16. The Immunization record indicated R36 had received a pneumococcal PPSV23 on 11/8/1996. At the time of the immunization R36 was 65 years old. The clinical record lacked indication R36 had received a pneumococcal vaccination PCV13. R47 was admitted to the facility on 9/3/16. R47 was 87 years old and the clinical record indicated R47 had received a pneumococcal vaccination on 3/2/07, which had been identified as a PPSV23, however, R47 had not received the pneumococcal booster PVC13. R45 was an 86 year old male admitted to the facility 7/27/16. R45's clinical record lacked information regarding if the pneumococcal vaccination was given or declined and whether information regarding the immunizations was provided to R45. On 9/20/16, at 9:22 a.m. the director of nurses (DON) stated she was aware of the updated	F 334	been reviewed. The DON or designee will audit new admissions for documented pneumococcal status. All audits will be submitted to the QAA Committee for comment and review.	

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F 334	Continued From page 5 guidance provided by the CDC in 2015. She reviewed the aforementioned resident clinical records and verified the identified concerns. She stated the facility had updated their immunization policy to follow the CDC guidelines, however, the facility had not completed reviewing the residents to see who was in need of further vaccinations. The facility Vaccine Adminstation Influenza and Pneumococcal policy dated 3/2015, indicated all residents were to be provided with the Pneumovax vaccine. The resident may be given a second pneumococcal vaccination as based on assessment and provider recommendations. The policy included an undated Pneumococcal Vaccination Pocket Guide as provided by the state immunization program.	F 334		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		10/21/16

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F 431	Continued From page 6 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication labels for insulin pens were accurate for 2 of 5 residents (R18, R38) who received insulin from an insulin pen which had inaccurate medication labels. Findings include: On 9/19/16, at 7:23 p.m. registered nurse (RN)-A was observed to remove R18's Lantus insulin pen from the medication cart. RN-A proceeded to calibrate R18's Lantus pen to 10 units. The medication label attached directly to R18's Lantus pen, directed staff to administer 16 units at bedtime. RN-A stated the label was incorrect and that R18's Lantus order had been changed to 10 units at bedtime. RN-A stated once the new pens	F 431	1. Prescription labels for R18's and R38's insulin pens have been replaced to match the doctor's orders. 2. All other insulin pen prescription labels have been compared to the physician□s orders and verified that the correct dosage is reflected on the insulin pen prescription label. 3. All licensed staff will be educated on proper medication administration per policy on 10/17/2016, and proper labeling of medications with dosage changes. DON or designee will do weekly audits x1 month to verify prescription on insulin pens reflect correct doctor's order dosage or have the "direction change refer to MAR" label affixed to the insulin pen. 4. All audits shall be presented to the QAA Committee for comment and review.	

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F 431	Continued From page 7	F 431		

arrived, the dosage instructions would be corrected. R18's Lantus insulin pen lacked an alert for staff to know that a change in dosage had occurred. RN-A proceeded to go to R18's room and administered 10 units of the Lantus insulin. RN-A failed to review R18's current Lantus order or check R18's electronic medication administer record (EMAR) prior to administering the 10 units of Lantus to ensure accuracy of the dose.

R18's Prescription Order dated 5/20/16, directed staff to administer 10 units of Lantus insulin at bedtime.

On 9/19/16, at 7:28 p.m. RN-A was observed to remove R38's Lantus insulin pen from the medication cart. RN-A calibrated R38's Lantus pen to 26 units. The medication label attached directly to R38's Lantus pen directed staff to administer 20 units at bedtime. RN-A confirmed the medication label was incorrect and that R38's Lantus order had been changed to 26 units at bedtime. R38's Lantus insulin pen lacked an alert for staff to know that a change in dosage had occurred. RN-A proceeded to go to R38's room and administered 26 units of Lantus insulin. RN-A failed to review R38's current Lantus insulin order or check R38's EMAR prior to administering the 26 units of Lantus insulin to ensure accuracy of the dose.

R38's Prescription Order dated 8/30/16, directed staff to administer 26 units of Lantus insulin at bedtime.

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F 431	Continued From page 8 On 9/20/16, at 9:24 a.m. licensed practical nurse (LPN)-A confirmed the following: - The medication label on R18's Lantus insulin pen in the medication cart directed staff to administer 16 units at bedtime. LPN-A confirmed R18's current order was to administer 10 units of Lantus at bedtime. LPN-A was unsure of when the order had been changed. LPN-A verified the medication label on R18's Lantus insulin pen was incorrect. - The medication label on R38's Lantus insulin pen in the medication cart directed staff to administer 20 units at bedtime. LPN-A confirmed R38's current order was to administer 26 units of Lantus at bedtime. LPN-A verified the medication label an R38's Lantus insulin pen was incorrect. On 9/20/16, at 12:37 p.m. the director of nursing (DON) verified R18's and R38's insulin orders. The DON confirmed all medication labels should include the right dose, route, frequency of administration, resident's name, prescription number and expiration date. When an order was changed, the pharmacist should relabel the medication as soon as possible. Until the medication could be relabeled a sticker indicating there had been change with the medication should be placed on the medication to alert staff they needed to check the physician's order to assure the correct dosage was being administered. The DON stated it was her expectation that prior to the administration of any medication the EMAR would be checked by the nursing staff as part of their medication administration procedure.	F 431		

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F 431	Continued From page 9 General Policies in Administering Medications dated 9/20/16, indicated only the pharmacist could label or change a medication label. If re-labeling was necessary the pharmacist should be called with the order change and a green "direction change refer to MAR" label should be placed on the medication. In addition, the identity of the medication should be verified three times with MAR, when taking the medication from the cart, when the medication was prepared and before it was replaced back in to the cart.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		10/21/16

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F 441	Continued From page 10 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facilty failed to develop an ongoing surveillance program to analyze patterns and trends of resident infections not treated with an antibiotic. This had the potential to affect all 31 residents residing in the facilty. Findings include: On 9/21/16, at 11:00 a.m. the facility infection control logs were reviewed with the director of nurses (DON). The logs consisted of a tracking form in which the staff identified the date in which symptoms were identified, the name of the resident, the room number in which the resident resided, if the identified symptoms were new or ongoing, the identified symptom, the type of infection, if a culture was completed, the name of the organisms, the type of antibiotic or treatment prescribed by the physician, if the infection was isolated, if it was acquired within the facility and	F 441	1. Current system for tracking active infections has been reviewed and will be kept in place. Facility site maps will also continue to be used by DON to track active infections, in addition to signs/symptoms of infections. 2. A log form has been created and will be placed in the nursing report book for all nurses to review and update every shift to track any signs/symptoms of infection not being treated by antibiotics. 3. DON or designee will review log and progress notes on all residents M-F, as well as audit use of signs/symptoms tracker 5x/week for 4 weeks. Tracker will be left in place with random audits for use after initial 4 weeks. 4. Reviews of audits shall be presented to the QAA Committee for comment and review.	

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F 441	Continued From page 11 the date in which the symptoms resolved. However, the logs did not contain the tracking or trending of any illness which was not being treated with an antibiotic. On 9/21/16, at 11:30 a.m. the DON who functions as the infection control practitioner stated only infections with prescribed antibiotics were tracked. She stated the facilty had not established a system to track infections which were not treated with antibiotics. The undated Outcome Surveillance for Healthcare Acquired Infection policy, directed the staff to monitor for infections or conditions which had been diagnosed by a physician. The policy did not direct the staff to monitor infections which were not treated with antibiotic therapy.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2016**

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Oakland Park Nursing Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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OAKLAND PARK COMMUNITIES	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Oakland Park Nursing Home is a 1-story building without a basement and was constructed in 1975. It was determined to be of Type II(111) construction. The facility is divided into 3 smoke zones by 30 minute fire barriers and is separated from the north apartment wing by a 2-hour fire barrier. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system with smoke detection at the smoke barriers for door release, in corridors and in common areas that are open to the corridor. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition).	K 000		

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	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2016**

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K 000	Continued From page 2 The facility has a capacity of 35 beds and had a census of 31 at the time of the survey The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 19.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This deficient practice could affect the ability of the alarm system to sound in a timely manner during	K 051	Smoke detectors will be installed down Sunshine corridor at a 30 ft. maximum separation distance. Planned completion date: 10/11/2016. The Maintenance Director or Administrator is responsible for coordinating the correction.	10/11/16

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K 051	Continued From page 3 a fire event which could affect all of the 31 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:30 am on 09/22/2016 observations and staff interview revealed the smoke detectors in the sunshine corridor exceeded the 30 feet maximum separation distance, only two served the entire corridor. This deficient condition was confirmed by the Maintenance Director.	K 051		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 31 residents, and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:30 am	K 062	Fire sprinkler system inspections will be conducted on a quarterly basis by the Maintenance Director. The most recent quarterly inspection was completed on 9/13/16. Completion of the quarterly inspection will be audited by the Maintenance Director or Administrator.	10/10/16

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K 062	Continued From page 4 on 09/22/2016 record review and staff interview revealed quarterly fire sprinkler system inspections were not being conducted. This deficient condition was confirmed by the Maintenance Director.	K 062		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 30, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5592025

Dear Ms. Erickson:

The above facility was surveyed on September 19, 2016 through September 22, 2016 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 19-22, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		10/21/16

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2 302	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide consumers with written or electronic information regarding the Alzheimer's training program. This had the potential to affect all 31 residents who resided in the facility and their families. Findings include: On 9/21/15, at 2:00 p.m. the administrator confirmed they currently had not provided information to their consumers regarding the details of their Alzheimer's training program, who the facility had trained, how often their staff was trained and the basic information which they covered. The Alzheimer's and Dementia Training policy indicated notice of dementia training describing the training program, who was trained and how often, and the basic topics covered would be provided to residents or residents' representative in writing upon admission and posted on Oakland Park Communities' website. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to the Alzheimer's information provided to consumers.	2 302	Corrected	

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2 302	Continued From page 4 The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 302		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facilty failed to develop an ongoing surveillance program to analyze patterns and trends of resident infections not treated with an antibiotic. This had the potential to affect all 31 residents residing in the facilty. Findings include: On 9/21/16, at 11:00 a.m. the facility infection control logs were reviewed with the director of nurses (DON). The logs consisted of a tracking form in which the staff identified the date in which symptoms were identified, the name of the resident, the room number in which the resident resided, if the identified symptoms were new or ongoing, the identified symptom, the type of infection, if a culture was completed, the name of	21375	Corrected	10/21/16

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21375	Continued From page 5 the organisms, the type of antibiotic or treatment prescribed by the physician, if the infection was isolated, if it was acquired within the facility and the date in which the symptoms resolved. However, the logs did not contain the tracking or trending of any illness which was not being treated with an antibiotic. On 9/21/16, at 11:30 a.m. the DON who functions as the infection control practitioner stated only infections with prescribed antibiotics were tracked. She stated the facilty had not established a system to track infections which were not treated with antibiotics. The undated Outcome Surveillance for Healthcare Acquired Infection policy, directed the staff to monitor for infections or conditions which had been diagnosed by a physician. The policy did not direct the staff to monitor infections which were not treated with antibiotic therapy. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or revise policies and procedures for infection control monitoring. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one	21375		

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21375	Continued From page 6 (21) Days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consistent documentation of the two step tuberculin skin test (TST) which would include the induration and interpretation of the test for 4 of 5 residents (R36, R47, R5, R45) and 5 of 5 nursing assistants (NA-A, NA-B, NA-C, NA-D, NA-E) reviewed. In addition 1 of 5 residents (R36) did not have a tuberculosis symptomology screen completed prior to the	21426	Corrected	10/21/16

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21426	Continued From page 7 administration of the TST. Findings include: Resident Review: R36 was admitted to the facility on 2/9/16. R36's clinical record contained a Resident TB Disease Risk Assessment form dated 2/9/16. However, the form was incomplete/blank. The clinical record indicated on 2/9/16, R36 received a TST, which was identified as a negative however, the induration of the TST was not recorded. R47 was admitted to the facility on 9/3/16. Review of the clinical record indicated R47 had received a TST on 9/3/16, which was read on 9/5/16. The results indicated the TST measured 0 millimeters (mm), however, the record lacked an interpretation of a positive or negative reading. R47 received a second TST on 9/17/16, which was read on 9/19/16. The induration was identified as 0 mm, however, the record lacked interpretation of the results. R5 was admitted to the facility on 8/11/16. The clinical record indicated R5 had received a TST on 8/11/16, which was read on 8/13/16. The results of the TST were recorded as 0 mm in induration, but the interpretation was not completed. The Electronic Medication Adminstation Record (EMAR), indicated R5 had received a second step TST on 8/25/16, which was read on 8/27/16. However, the results of the second step TST were not recorded in the clinical record.	21426		

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21426	Continued From page 8	21426		

R45 was admitted to the facility on 7/27/16. R45's clinical record indicated R45 had received a TST test on 7/27/16, which was read on 7/29/16. The results of the TST were recored as 0 mm, but the interpretation was not completed. The clinical record lacked indication R45 had received a second step TST.

On 9/20/16, at 9:20 a.m. the director of nurses (DON) reviewed the aforementioned resident TST results. She stated all residents were to receive a TB screening prior to the administration of the TSTs. The residents were then to receive a two step TST as indicated by the TB screening results. She stated the clinical record was to contain both the induration and the interpretation of the TST results. She reviewed the computerized electronic record and stated the computer system had areas in which the staff were to record the induration of the TST results, but did not allow space for the interpretation.

Staff Review:

NA-A was hired on 8/4/16. NA-A received a first step TST on 7/27/16, which was read on 7/19/16. The results of the TST were recorded as 0 mm however, the TST lacked interpretation. NA-A received a second step TST on 8/24/16. The results were identified as 0 mm however, the interpretation was not recored. NA-A received a third TST on 9/7/16, and read on 9/10/16. The results of the TST were interpreted as negative, however, the induration was not recored.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 9	21426		

NA-B was hired on 6/2/16. NA-B received a first step TST on 6/15/16., which was read on 6/17/16. The results indicated 0 mm with slight redness. The record lacked an interpretation of the results. NA-B received a second step TST on 6/25/16, which was read on 6/27/16. The results were recorded as 0 mm, however, the record lacked interpretation.

NA-C was hired on 5/1816. NA-C received a first step TST on 5/17/16, which was read on 5/19/16. The results were recorded as 0 mm without an interpretation. NA-C received a second step TST on 6/2/16, which was read on 6/5/16. The results were recorded as 0 mm however; the documentation lacked interpretation of the results.

NA-D was hired on 8/29/16. NA-D received a first step TST on 8/29/16. which were read on 9/1/16. The results were recorded as 0 mm without interpretation. NA-D received a second step TST on 9/12/16. the results were recored 9/15/16, as 0 mm but lacked interpretation of the test.

NA-E was hired on 8/16/16. NA-E received a first step TST on 8/16/16, however, the results were not recored. On 8/24/16, NA-E received a second step TST. On 8/26/16, the results were recorded as 0 mm without induration. NA-E received a third step TST on 9/7/16, which was read on 0/0/16. The results were recorded as 0 mm however; the interpretation was not recorded.

On 9/21/16, the DON verified the aforementioned NAs had received their TST's however, the staff

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	00449	A. BUILDING: _____ B. WING _____	09/22/2016

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21426	Continued From page 10 failed to document the interpretation and the induration of the test results. The Tuberculosis Control Plan policy dated 3/2015, directed the staff to complete a TB screening on newly admitted residents and newly hired employees. Following the screening, the staff were to receive a two step TST (as appropriate). The policy directed the staff to identify the induration and interpretation of the TST results but did not direct the staff to document these results. On 9/21/16. at 9:30 a.m. the DON verfied the policy did not specifically direct the staff to document the induration and the interpretation of the TST results but added she would expect this to be in the documentation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled	21620		10/21/16

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21620	Continued From page 11 in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication labels for insulin pens were accurate for 2 of 5 residents (R18, R38) who received insulin from an insulin pen which had inaccurate medication labels. Findings include: On 9/19/16, at 7:23 p.m. registered nurse (RN)-A was observed to remove R18's Lantus insulin pen from the medication cart. RN-A proceeded to calibrate R18's Lantus pen to 10 units. The medication label attached directly to R18's Lantus pen, directed staff to administer 16 units at bedtime. RN-A stated the label was incorrect and that R18's Lantus order had been changed to 10 units at bedtime. RN-A stated once the new pens arrived, the dosage instructions would be corrected. R18's Lantus insulin pen lacked an alert for staff to know that a change in dosage had occurred. RN-A proceeded to go to R18's room and administered 10 units of the Lantus insulin. RN-A failed to review R18's current Lantus order or check R18's electronic medication administer record (EMAR) prior to administering the 10 units of Lantus to ensure accuracy of the dose. R18's Prescription Order dated 5/20/16, directed staff to administer 10 units of Lantus insulin at bedtime.	21620	Corrected	

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21620	Continued From page 12 On 9/19/16, at 7:28 p.m. RN-A was observed to remove R38's Lantus insulin pen from the medication cart. RN-A calibrated R38's Lantus pen to 26 units. The medication label attached directly to R38's Lantus pen directed staff to administer 20 units at bedtime. RN-A confirmed the medication label was incorrect and that R38's Lantus order had been changed to 26 units at bedtime. R38's Lantus insulin pen lacked an alert for staff to know that a change in dosage had occurred. RN-A proceeded to go to R38's room and administered 26 units of Lantus insulin. RN-A failed to review R38's current Lantus insulin order or check R38's EMAR prior to administering the 26 units of Lantus insulin to ensure accuracy of the dose. R38's Prescription Order dated 8/30/16, directed staff to administer 26 units of Lantus insulin at bedtime. On 9/20/16, at 9:24 a.m. licensed practical nurse (LPN)-A confirmed the following: - The medication label on R18's Lantus insulin pen in the medication cart directed staff to administer 16 units at bedtime. LPN-A confirmed R18's current order was to administer 10 units of Lantus at bedtime. LPN-A was unsure of when the order had been changed. LPN-A verified the medication label on R18's Lantus insulin pen was incorrect. - The medication label on R38's Lantus insulin pen in the medication cart directed staff to administer 20 units at bedtime. LPN-A confirmed R38's current order was to administer 26 units of	21620		

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21620	Continued From page 13 Lantus at bedtime. LPN-A verified the medication label an R38's Lantus insulin pen was incorrect. On 9/20/16, at 12:37 p.m. the director of nursing (DON) verified R18's and R38's insulin orders. The DON confirmed all medication labels should include the right dose, route, frequency of administration, resident's name, prescription number and expiration date. When an order was changed, the pharmacist should relabel the medication as soon as possible. Until the medication could be relabeled a sticker indicating there had been change with the medication should be placed on the medication to alert staff they needed to check the physician's order to assure the correct dosage was being administered. The DON stated it was her expectation that prior to the administration of any medication the EMAR would be checked by the nursing staff as part of their medication administration procedure. General Policies in Administering Medications dated 9/20/16, indicated only the pharmacist could label or change a medication label. If re-labeling was necessary the pharmacist should be called with the order change and a green "direction change refer to MAR" label should be placed on the medication. In addition, the identity of the medication should be verified three times with MAR, when taking the medication from the cart, when the medication was prepared and before it was replaced back in to the cart. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could	21620		

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21620	Continued From page 14 develop and implement policies and procedures to ensure that all medications are labeled and stored properly. Education could be provided to all staff and monitoring systems could be developed to ensure ongoing compliance. The findings could be reported to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		