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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XLBJ

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 **12/30/2013** (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:
X 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: **A1*** (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):

CCN-245398
Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective December 19, 2013, the facility is certified for 35 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Mary Whitlock, HFE NE II 12/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/10/2014 (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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/23/2013** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245398

January 15, 2014

Mr. Christopher Knoll, Administrator
Parker Oaks Communities Inc
211 Sixth 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 December 19, 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.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

January 15, 2014

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

RE: Project Number S5398025

Dear Mr. Knoll:

On November 25, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2013 . 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 December 30, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 16, 2013 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 November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 7, 2013, effective December 19, 2013 and therefore remedies outlined in our letter to you dated November 25, 2013, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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	12/30/2013

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 F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	12/19/2013	ID Prefix F0329 Reg. # 483.25(l) LSC	12/19/2013	ID Prefix F0334 Reg. # 483.25(n) LSC	12/03/2013
ID Prefix F0428 Reg. # 483.60(c) LSC	12/19/2013	ID Prefix F0441 Reg. # 483.65 LSC	12/19/2013	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	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/KJ	1/15/2014	MW 28588	12/30/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/7/2013

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

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 **01 - MAIN BUILDING 01**	12/16/2013

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 K0062	Correction Completed **12/10/2013**	ID Prefix Reg. # **NFPA 101** LSC K0069	Correction Completed **12/05/2013**	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/KJ	1/15/14	25822	12/16/2013
Reviewed By CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/7/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XLBJ
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 **11/07/2013** (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 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

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):

At the time of the Standard survey completed November 7, 2013, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. PCR to follow.

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HFE NEII 12/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/19/2013 (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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7814

November 25, 2013

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

RE: Project Number S5398025

Dear Mr.. Knoll:

On November 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 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:

> <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;**

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

<u>Informal Dispute Resolution</u> - 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:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

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 December 17, 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 December 17, 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. 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 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 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 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 February 7, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 7, 2014 (six months after the identification

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

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

PRINTED: 11/25/2013
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 ______	11/07/2013

NAME OF PROVIDER OR SUPPLIER: PARKER OAKS COMMUNITIES INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 211 8TH 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	RECEIVED DEC 0 5 2013 Minnesota Dept of Health Mankato	
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	F 279	approved [illegible] 12/6/13 F – 279 It is the intent of Parker Oaks Communities Inc. to develop a comprehensive care plan addressing the needs of each resident. R3's care plan has been updated to reflect their current status. Parker Oaks has implemented a new daily behavior observation sheet to better monitor behaviors. Nursing staff will be re-educated on the new behavior sheet on December 19th. The education will cover the topic of accurately documenting behaviors and how to use the new form.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Admin. (X6) DATE: 12-5-13

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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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 ______	11/07/2013

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 279	Continued From page 1 by: Based on interview and document review the facility failed to develop a plan of care that addressed the behavioral needs for 1 of 1 resident (R3) reviewed who required behavioral management. Findings include: A care plan had not been developed to include the behaviors exhibited by R3 so that consistent approaches and interventions could be implemented. Record review indicated R3 had been admitted on 7/16/13 and had current physician orders to receive Zoloft 100 milligrams (mg) daily at bedtime for diagnoses that included dementia with behavioral issues and depression; and Ativan 0.5 mg twice daily as needed for anxiety. The pharmacist notes dated 9/17/13 indicated the Zoloft had been increased in March 2013, due to an increase in the resident's behaviors and that as needed (PRN) Ativan had been utilized several times per month; sometimes effective, other times minimal or not effective response. Review of the facility's monthly behavior flow sheets identified the following behaviors: self-transferring, stuffing napkins and other items into pants and smearing phlegm on side of recliner. During interview with the director of nursing on 11/7/13 at 10:00 a.m., the DON denied being aware of any behaviors exhibited by R3. The DON stated during an additional interview on 11/7/13 at 11:45 a.m., that after discussion with staff it was confirmed that R3 did exhibit behaviors, but that staff had not been recording all behaviors exhibited. R3's care plan was reviewed, and did not include any interventions to address the behaviors R3 exhibited, including anxiety and yelling. There had been no non-pharmacological interventions	F 279	Random daily audits will be done x 1 month of all residents with a daily behavior observation sheet. Parker Oaks will continue to monitor on a weekly basis x 1 month or until compliance is met. The Director of Social Services or their designee will be responsible for the audit. The results will be brought to the Quality Council for further recommendations. Date Compliant 12/19/13 RECEIVED DEC 0 5 2013 Minnesota Dept of Health Mankato	

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F 279	Continued From page 2 developed to address the behaviors exhibited by R3.	F 279		
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 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 ensure that 2 of 5 residents (R3 and R6) reviewed for unnecessary medications, had clear indications, defined parameters, and adequate monitoring for the use of psychoactive	F 329	F – 329 It is the intent of Parker Oaks Communities Inc. to ensure each resident drug regimen is free from any unnecessary drugs. R6's drug regimen has been reviewed. Parker Oaks has updated our daily behavior observation sheets to represent resident's target behaviors. Resident's doctor has documented justification for the continued use of the current medications. R6's care plan has been updated to reflect current status. R3's drug regimen has been reviewed and updated to reflect current status to justify use of medications. Parker Oaks has updated our daily behavior observation sheets to ensure consistent, accurate monitoring and individualized interventions for any resident who are exhibiting behaviors.	

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F 329	Continued From page 3 medications. Finding include: R6 was admitted on 7/19/04, with diagnosis that included depression and anxiety disorder. Review of R6s medication record identified the resident as receiving Buspar 15 milligrams (mg) bid (twice a day) (used for anxiety) and Paxil 40 mg daily (an antidepressant). Review of the medical record indicated that R6 had received the same dosages of Buspar and Paxil over the past year, without a dose reduction. The record indicated R6's mood and behavior had been monitored in June and July 2013, and the resident had exhibited yelling out and being resistive with taking medications 1-2 times per week. No further documentation of the R6's mood and/or behaviors was evident in the medical record since that time (3 months ago). Review of the physician's progress notes over the past year did not include any documented justification for the continued use of the Buspar and Paxil for R6. Review of the pharmacist recommendation dated 2/20/13, documented a recommendation for the physician to review the Buspar and Paxil for dose reductions and if no changes were warranted, to document the clinical rationale. The physician had documented "no changes" at that time, but had documented any medical justification or rationale for his decision. Interview with the director of nursing (DON) on 11/7/13 at 11:00 a.m., confirmed there was no documentation in the record, to justify the continued use of the medications. She further	F 329	Parker Oaks has Implemented a new "Behavioral Monitoring" Policy and Procedure. Random daily audits will be done x 1 month of any resident with a daily behavior observation sheet. Parker Oaks will continue to monitor on a weekly basis x 1 month or until compliance is met. The Director of Social Services or their designee will be responsible for the audit. The DON or designee will audit x3 months that an RN summary is being completed on a monthly basis. The results will be brought to the Quality Council for further recommendations. Staff education is to take place on December 19th. Date compliant: 12/19/13	

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

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F 329	Continued From page 4 confirmed that mood and behavior monitoring for R6 had not been consistently implemented. Record review indicated R3 had been admitted on 7/16/13 and had current physician orders to receive Zoloft (an antidepressant) 100 milligrams (mg) daily at bedtime, and Ativan (an antianxiety) 0.5 mg po BID (twice a day), for diagnoses that included dementia with behavioral issues and depression. Review of the facility's monthly behavior flow sheets identified the following behaviors: self-transferring, stuffing napkins and other items into pants and smearing phlegm on side of recliner. During interview with the director of nursing on 11/7/13 at 10:00 a.m., the DON denied being aware of any behaviors exhibited by R3. The DON stated during an additional interview on 11/7/13 at 11:45 a.m., that after discussion with staff it was confirmed that R3 did exhibit behaviors, but that staff had not been recording all behaviors exhibited. The DON verified that a dose reduction had not occurred in the past year. A pharmacy recommendation dated 9/17/13, indicated R3 was being reviewed to determine whether a trial dose reduction of Zoloft was needed. The pharmacist notes indicated the Zoloft had been increased in March 2013, due to an increase in the resident's behaviors and that the PRN Ativan had been utilized several times per month and was sometimes effective, other times minimally effective, or no effective response. The pharmacy review dated 9/17/13, also indicated the Zoloft was not likely appropriate for a dose reduction due to R3's continued behaviors of anxiety with yelling, in combination with the underlying dementia diagnosis. The recommendation indicated: continuing Zoloft for baseline management of symptoms of dementia is advisable.	F 329		

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F 329	Continued From page 5 Record review verified a lack of consistent behavioral monitoring, which would make it difficult to monitor R3's response to, and effectiveness of, the medication.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (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	F 334	F -- 334 It is the Policy and Procedure of Parker Oaks Communities Inc. to educate the resident and/or resident's legal representative of the benefits and potential side effects of the Influenza and Pneumococcal immunization. Parker Oaks has re-written its policy "Influenza and Pneumococcal Immunizations." Parker Oaks has also added it to the "Health Care Authorization" form used at resident admission. Parker Oaks will ensure the vaccine information statement and consent is mailed out in a self-addressed stamped envelope to each resident/resident's legal representative. If Parker Oaks does not get a response in a timely manner we will contact the legal representative via phone.	

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F 334	Continued From page 6 legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive 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 develop and implement a policy which included that information be provided regarding the benefits and risks of influenza immunization prior to the administration of the	F 334	This will be monitored by the D.O.N and/or designee to ensure compliance is met. The immunization log will be brought to Quality Council. Date Compliant: 12/3/2013	

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F 334	Continued From page 7 vaccine for 3 of 5 residents (R15, R20 & R28) reviewed who had received the vaccination during the current influenza season. Findings include: Documentation was lacking to verify that R15, R20 and R28 (or their representatives) had been informed of the benefits and potential side effects of influenza immunization prior to the administration of this vaccination in October 2013. During review of the policy and procedure titled, FLU SHOT ADMINISTRATION POLICY dated September 2005, it made no mention of ensuring the resident or resident's legal representative were provided with education regarding the benefits and potential side effects of the influenza immunization prior to being offered the immunization. The policy included: (1) only administered with physicians order and family/POA/resident written consent; and (2) administered yearly at the beginning of flu season in autumn. The undated HEALTH CARE AUTHORIZATION FORM was reviewed. This document was used by the facility to verify whether the resident or resident's representative had received information and had provided their consent for various treatments. The document had a check box identified for each area that required consent which included the following: Tetanus booster; Pneumococcal Polysaccharide vaccine (PPV); Dental care and Eye care. This Authorization Form lacked any mention of the influenza immunization. An undated form titled, CHART DATA/IMMUNIZATION SHEET was identified in	F 334		

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F 334	Continued From page 8 the medical record. This form was utilized to document the date the resident received the influenza immunization and whether information/education related to the risks and benefits of immunization had been provided. Documentation on this form was lacking to indicate the information had been provided for R15, R20 and R28. Medication Administration Records were reviewed and verified influenza immunizations had been administered to R15 and R20 on 10/11/13, and to R28 on 10/21/13. The above information was verified by the director of nursing on 11/7/13 at 10:03 a.m.	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility pharmacist failed to ensure residents were free from unnecessary medications for 1 of 5 residents (R6) reviewed for unnecessary medications. Finding include:	F 428	F – 428 It is the intent of Parker Oaks Communities Inc. to ensure each resident drug regimen is free from any unnecessary drugs. R6's drug regimen has been reviewed. Parker Oaks has updated our daily behavior observation sheets to represent resident's target behaviors. Resident's doctor has documented justification for the continued use of the current medications. R6's care plan has been updated to reflect current status. R3's drug regimen has been reviewed and updated to reflect current status to justify use of medications. Parker Oaks has updated our daily behavior observation sheets for consistent monitoring of target behaviors to meet the needs of other appropriate residents.	

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F 428	Continued From page 9 R6 was admitted on 7/19/04 with diagnosis that included depression and anxiety disorder. Review of R6s medication record identified that R6 received Buspar 15 mg (milligrams) bid (twice a day) for anxiety and Paxil 40 mg daily (an antidepressant). Review of the medical record indicated that R6 had received the same dose of Buspar and Paxil over the past year, without a dose reduction. The record indicated R6's mood and behavior had been monitored in June and July 2013 and the resident had exhibited yelling out and being resistive with taking medications 1-2 times per week. No further documentation of the R6's mood and/or behavior was evident in the medical record since that time (3 months ago). Review of the physician's progress notes for the past year did not include justification for the continued use of the Buspar and Paxil for R6. During review of the pharmacist monthly drug regimen review dated 2/20/13, the following recommendation had been made to the physician: review the Buspar and Paxil for dose reduction and if no changes were warranted, document the clinical rationale. The physician noted 'no changes' at that time but failed to document a rationale for their continued use. No further pharmacy recommendations were noted since the 2/20/13 recommendation, relative to the Buspar and Paxil. Interview with the director of nursing (DON) on 11/7/13 at 11:00 a.m. confirmed that documentation over the past year, to justify the continued use of the medications, Buspar and Paxil, was not evident in the medical record. She further confirmed the pharmacist had not addressed in the monthly drug regimen reviews	F 428	Parker Oaks has implemented a new "Behavioral Monitoring" Policy and Procedure. Random daily audits will be done x 1 month of any resident with a daily behavior observation sheet. Parker Oaks will continue to monitor on a weekly basis x 1 month or until compliance is met. The Director of Social Services or their designee will be responsible for the audit. The DON or designee will audit x3 months that an RN summary is being completed on a monthly basis. The results will be brought to the Quality Council for further recommendations. Staff education is to take place on December 19th. Date compliant: 12/19/13	

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F 428	Continued From page 10 since 2/20/13, the need for the physician to document the clinical rationale for the continued use of these medications.	F 428		
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 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	F 441	F - 441 It is the Policy of Parker Oaks Communities Inc. to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. Parker Oaks has implemented an infection control surveillance log to track and trend infections amongst staff and residents. This log will be audited by the D.O.N or her designee monthly x 3 months. The data will be analyzed monthly with any trends being examined for further interventions. The results of this audit will be brought to the Quality Council for further recommendations. Staff will be re-educated on the importance of communicating any illness or disease to our Business Office designee. Education is to take place on December 19th. Date Compliant: 12/19/13	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop, implement, and maintain an infection prevention and control program related to the surveillance, investigation, and analysis of resident and staff diseases/infections in order to prevent, recognize and control, to the extent possible, the onset and spread of infection within the facility which could potentially affect the resident census of 25. Findings include: Review of the facility infection control surveillance logs for both residents and staff revealed the facility lacked a resident and employee illness/disease tracking and trending system. Documentation was not available to indicate that outcome or process surveillance had been implemented, infections had been monitored, antibiotic usage had been trended nor had individual resident infections been analyzed. Tracking staff infections relative to resident illness had not been integrated into the infection control program. Interview with the director of nursing on 11/7/13 at 10:03 a.m. verified the facility had noted whether a resident had received antibiotics but no further evaluation/analysis had been completed with this information. No antibiotic trending had been completed to determine whether antibiotics had been utilized appropriately and/or over-utilized.	F 441		

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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 ______	11/07/2013

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245398	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2013

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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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 12-13-13 RECEIVED DEC 0 5 2013 Minnesota Dept of Health Mankato RECEIVED DEC - 5 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 11-7-13
DC: 12-23-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admin. | (X6) DATE 12-5-13

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.

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

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	245398	A. BUILDING 01 - MAIN BUILDING 01 B. WING ___	11/07/2013

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 1 446 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 25 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	RECEIVED DEC 0 5 2013 Minnesota Dept of Health Mankato	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062	Continued From page 2 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 9-4.2.1 and 10-2.2. This deficient practice could affect all 25 residents. Findings include: On facility tour between 9:30 AM and 12:00 noon on 11/07/2013, the review of the annual sprinkler inspection report from Olympic Fire Protection dated 10/4/2013. Item # 18 indicated that it was unknown when the: 1. Last time the 5 year main check valve has been internally inspected 2. Last time a internal pipe inspection has been done on the wet and dry sprinkler system No documentation stating this as been done. This deficient practice was confirmed by the Administrator (CK) at the time of discovery.	K 062	K – 62 It is the intent of Parker Oaks Communities Inc. to ensure our automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. We have scheduled an inspection of the main check valve with Olympic Fire Protection on December 10th. This will be added to the Preventative Maintenance book and will be monitored every 5 years by the Chief Building Inspector. Date Compliant: 12/10/13 RECEIVED DEC 0 5 2013 Minnesota Dept of Health Mankato	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		

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K 069	Continued From page 3 with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not maintained in accordance with 2000 NFPA 101 - 9.2.3 and 1998 NFPA 96 section 8.2. This deficient practice could affect all 25 residents. Findings include: On facility tour between 9:30 AM and 12:00 noon on 11/07/2013, the review of the kitchen hood system inspection documentation for the past 12 months revealed that the kitchen hood was not inspected every 6 months. The last documented inspection was on 4/30/2013. This deficient practice was confirmed by the Administrator (CK) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 069	K – 69 It is the intent of Parker Oaks Communities Inc. ensure the kitchen's cooking hood fire extinguishing system is maintained appropriately. Parker Oaks has scheduled Central Fire Protection to come inspect the system on December 5th 2013. This will be monitored by the Chief Building Inspector going forward. Date Compliant: 12/5/13 RECEIVED DEC 0 5 2013 Minnesota Dept of Health Mankato	