DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 6, 2025

Administrator
Oakland Park Nursing Home
123 Baken Street
Thief River Falls, MN 56701

RE: CCN: 245592
Cycle Start Date: January 30, 2025

Dear Administrator:

On February 13, 2025, we notified you a remedy was imposed. On March 5, 2025 and May 2, 2025 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 26, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 13, 2025 be discontinued as of March 26, 2025. (42 CFR 488.417 (b))

In our letter of February 13, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 28, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Your request for a waiver involving the deficiency cited under K761 at the time of the January 30, 2025 survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2025

Administrator
Oakland Park Nursing Home
123 Baken Street
Thief River Falls, MN 56701

RE: CCN: 245592
Cycle Start Date: January 30, 2025

Dear Administrator:

On February 13, 2025, we informed you of imposed enforcement remedies.

On March 4, 2025, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

K321 - S/S: F - NFPA 101 -- Hazardous Areas - Enclosure Bld: 01
K761 - S/S: F - NFPA 101 -- Maintenance, Inspection & Testing - Doors Bld: 01

As a result of the revisit findings:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 30, 2025

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 30, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 30, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of February 13, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from NO DATA. However, due to the extended survey the new NATCEP loss date is February 28, 2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

DEPARTMENT CONTACT

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 30, 2025 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information

Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 13, 2025

Administrator
Oakland Park Nursing Home
123 Baken Street
Thief River Falls, MN 56701

RE: CCN: 245592
Cycle Start Date: January 30, 2025

Dear Administrator:

On January 30, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 28, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 28, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 28, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 28, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Oakland Park Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 28, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 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.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 30, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the

cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division

Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK NURSING HOME	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
E 000	Initial Comments On 1/27/25 through 1/30/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff	E 015		2/28/25

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

Electronically Signed | 02/22/2025

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 _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK NURSING HOME	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
E 015	Continued From page 1 and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure policies and procedures	E 015	Failure of the facility's Emergency Preparedness plan to adequately	

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 _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK NURSING HOME	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
E 015	Continued From page 2 included subsistence needs for residents and staff in the event sheltering in place was necessary. This practice had the potential to affect all 32 residents who resided at the facility. Findings include: A review of the facility's emergency preparedness plan (EPP) 1/25, was conducted on 1/30/25 . The EPP policies and procedures failed to address sustenance needs for staff and residents in the event of emergency. On 1/30/25, at approximately 11:45 a.m. the EPP was reviewed with the director of nursing who confirmed there was no policy which addressed the facilities subsistence needs which would include the amount and type of food needed in the case of an emergency.	E 015	addresses subsistence needs for residents and staff during shelter-in-place events has the potential to negatively affect all staff and residents during an emergency. On 2/21/25 a menu was reviewed and approved by the registered dietitian to support the subsistence needs for the facility for a 7-day emergency period. By 2/28/25, the resources needed to implement the menu will be available within the facility. The Emergency Preparedness Manual will be updated with the approved menu by 2/28/25. Staff will be informed of the emergency menu and food stores at an all-staff meeting held between the dates of 2/24/25 and 2/28/25. The dietary manager will be responsible for auditing food stores the last week of every month to ensure adequate supplies that are within acceptable date ranges. This audit will be documented on an audit form to include adequate supplies and notation of supplies that are reordered and turned in to the administrator each month for review on an ongoing basis. Results of audits completed by the dietary manager will be reported at QAPI on a quarterly basis for ongoing review and identification needed of procedural changes.	
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1),	E 030		2/28/25

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
OAKLAND PARK NURSING HOME	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
E 030	Continued From page 3 §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030		

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	245592	A. BUILDING _____ B. WING _____	C 01/30/2025

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E 030	Continued From page 4 (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030		

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E 030	Continued From page 5 (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure policies and procedures included all requirered contact information for current staff. This had the potential to affect all 32 residents of the facility. Finding include: A review of the facility's emergency preparedness plan (EPP) dated 1/25, was conducted on 1/30/25. The EPP policies and procedures failed to include all required information including contact information of the facility staff. On 1/30/25, at approximately 11:45 a.m. the EPP was reviewed with the director of nursing who confirmed there was no information in the EPP plan that included names and contact information for the current staff.	E 030	Failure of the facility's Emergency Preparedness Plan (EPP) to contain the required staff contact information listing for staff has the potential to hinder emergency response efforts in the case of an emergency. On 2/21/25 a comprehensive staff contact list (name, title, primary/secondary/emergency contacts) was placed into the physical binders containing the emergency response procedures. Staff will be educated of the Emergency Preparedness Emergency Contact List and where to locate during an all staff meeting being held between the dates of 2/24/25 and 2/28/25. Education will include where to locate the list and also and the importance of maintaining current contact information within facility records. The contact list will be updated monthly the first week of the month with new hires being added and terminated staff being removed by the Administrator. Audits will be conducted monthly for 3 months beginning 3/2025 by the Corporate RN to ensure contact information has been updated and is available to staff at all times. Results of audits will be reviewed during quarterly QAPI meeting to be held in 4/2025 and 7/2025 for determination of ongoing auditing needs.	

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E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		2/28/25

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E 039	Continued From page 7 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using	E 039		

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E 039	Continued From page 8 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.	E 039		

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E 039	Continued From page 9 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E 039		

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E 039	Continued From page 10 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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E 039	Continued From page 11 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that	E 039		

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E 039	Continued From page 12 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.	E 039		

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E 039	Continued From page 13 (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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E 039	Continued From page 14 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure for after action reports were completed following exercise's to test their emergency preparedness program plan (EPP). This had the potential to affect all 32 residents who currently resided in the facility. Findings include: The facility's EPP dated 1/25, included evidence of a table top threat call scenario completed	E 039	Failure to complete after-action reports and adequately document emergency preparedness exercises has the potential to affect all staff and residents during an emergency. The Administrator will complete comprehensive after-action reports for all previous exercises completed in the previous calendar year by 2/28/25 and these ARR's will be placed in the EP binder. Additionally, the facility has	

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E 039	Continued From page 15 8/8/24, and an IT Failure and Communications Tabletop Exercise completed 1/24/24; however, there was no evidence of particpants, an after-action report or discussion of the facility's response for either of the exercises. During an interview on 1/30/25 at 11:45 a.m., the director of nursing (DON) stated she was only able to find the general agenda's for the exercises and could not find documentation of the completed exercises. She was not employed by the facility during the time the exercises were completed and the administrator was unavailable for interview. The facility's EPP plan/policy dated 1/2025, identified the facility was commited to present exercises and drills to test the skills they facility intended to instill in their staff. The EPP plan identified the following pages would document the training and testing that the facility had completed and record the staff members who were involved. The following pages, however, were blank.	E 039	registered for an EP tabletop drill to be facilitated by the coalition to be held on 3/27/25. A second exercise will be conducted prior to 9/2025 to ensure compliance for calendar year 2025. Audits will be completed via a review of AAR documentation from exercises completed in 2024. This will conducted by the Corporate RN to verify completion and compliance with expectations with state and federal regulation for exercises held in 2024. 2025 exercises will be audited for compliance within 1 week of completion by the corporate nurse or designee. Ongoing audits for compliance with emergency exercises will be completed by the corporate nurse every 6 months for 2 years.	
F 000	INITIAL COMMENTS On 1/27/25 through 1/30/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55925840C (MN108783) with a deficiency cited at (F697). H55926444C (MN110308) with a deficiency cited at (F697). The facility's plan of correction (POC) will serve	F 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND PARK NURSING HOME	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	Continued From page 16 as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		2/28/25

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F 580	Continued From page 17 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform the physician of a burn for 1 of 1 resident (R15) reviewed for burns; and failed to inform the physician of a resident fall with significant bruising 1 of 1 resident (R29) reviewed for falls. Findings include: R15: R15's quarterly Minimum Data Set (MDS) dated 10/10/24, identified R15 had a moderate cognitive impairment and diagnoses that included	F 580	Failure to inform the physician of an accident involving the resident which results in injury and has the potential to affect all residents. R15's provider was notified of the burn incident on 11/7/2024 and resident was evaluated in urgent care for R15s right hip wound and continues to have scheduled visits with wound therapy. R29's fall was reported to primary care on 12/3/2025 during an office visit, hip X-rays were obtained and negative. All falls and skin concerns occurring in the past 30 days audit completed by the DON	

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F 580	Continued From page 18 weakness, type 2 diabetes, and chronic kidney disease. R15 required partial to moderate asssistance to roll her body left and right and was at risk for pressure ulcers. R15's care plan dated 10/16/24, identified R15 was at risk for pain related to spinal stenosis, osteoporosis, weakness, impaired mobility, shoulder pain, spondylolisthesis osteoarthritis, chronic gout, low back pain, and amputation of the second toe of the right foot. Non-pharmacological pain interventions may include: rest, reposition, distraction, elevation and ice/warm pack. The care plan directed to update R15's physician with changes. R15's nursing progress notes identified the following: - 10/19/24 at 8:49 a.m., a voicemail was left for family member (FM)-A. R15 was complaining of right hip pain, would note rate pain. As needed (PRN) Tylenol and heat pack applied. - 10/19/24 at 12:05 p.m., a (nursing assistant) NA noted a blister measuring 4 centimeter (cm) x 1.5 cm on R15's right hip related to heat pack being applied. Heat pack was not overly warm, but R15 did have fragile skin and did lay on the heat pack which may have contributed to blister occurring. R15 denied pain in hip or blister. Blister left open to air. FM-A informed and stated R15's skin was very thin and likely why it blistered easily. The note failed to identify if R15's physician had been notified. - 10/20/24 at 11:31 a.m., R15's blistered area was leaking clear fluid. The area was cleansed, and an ABD pad placed. The note failed to provide a	F 580	on 02/21/2025 with no additional incidents with missed notifications identified. The facility policy for notification to providers has been reviewed on 1/21/25 with no changes made. An in-service education program was developed based on the fall and skin policy and staff will be educated at an all staff meeting between the dates of 2/24/25 and 2/28/25. Education will include an emphasis on circumstances that require notification of the resident's physician, legal representative or family member and timing of notification. The Director of Nursing Services, or designee, will review documentation the next business day after a new skin concern or fall is noted for 6 weeks. Following the initial 6 weeks of audits, review by the DON will occur at least weekly on an ongoing basis. Noncompliance with notification expectations will result in a review of the findings with the nurse responsible, notifications being made immediately, and additional correction action as needed. Results of audits will be reported at QAPI meeting to be held 4/2025 for determination of ongoing auditing needs.	

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F 580	Continued From page 19 description including measurements or if R15's physician had been notified. -10/23/24 at 11:42 a.m., R15's routine skin check performed this shift. No new skin concerns noted. Dressing to right hip/thigh changed. Scant amount of serous fluid noted on old dressing. Cleansed and new dressing applied. Tolerated well. Area has no odor or signs/symptoms of infection. The note failed to identify if R15's physician was notified. - 10/23/24 at 9:51 p.m., R15's dressing to right thigh changed due to previous dressing being soiled. Moderate amount of serous fluid noted on old dressing. No odor noted. Area cleansed with normal saline, and dressing changed per treatment record order. Tolerated well. The note failed to identify if R15's physician was notified. - 10/26/24 at 3:00 p.m., R15 had a bath. Telfa (a non-absorbent and non-adhering dressing) and an ABD applied to right outer hip blister/wound. The outer edges of area were red in color and measure 7.5 cm x 4.5 cm, this was area on entire wound. Blister was intact and fluid filled. Resident had no complaints of pain within that area and tolerated dressing change well. However, the note failed to identify if R15's physician was notified. - 11/4/24 at 3:27 p.m., R15's skin assessment was completed: 8 cm x 5.5 cm area to right hip that was previously a fluid filled blister in evolution. Skin remained intact. Peri wound was reddened. No warmth noted. Wound edges are smooth. Area was dry and flaky skin noted. Darken discoloration noted to right posterior and left anterior edges. Center of wound had pale	F 580		

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F 580	Continued From page 20	F 580		

color. No drainage to area. Area covered with xeroform and ABD, secured with tape. R15 had no complaints of pain to area. Will change dressing to area daily.

- 11/5/24 at 11:22 a.m., a new dressing was applied to right thigh due to old dressing falling off. No drainage noted coming from area, no odor noted. Peri wound reddened; no warmth noted. Area where blister was dark in color. Dressing changed per orders. Resident tolerated well. However, the note failed to identify if R15's physician was notified.

- 11/7/24 at 7:56 a.m., a 7 cm x 5 cm area to right hip that was previously a fluid filled blister in evolution. Skin remains intact. Peri wound was reddened. No warmth noted. Wound edges were smooth. Area was dry and flaky skin noted. Darken discoloration noted to right posterior and left anterior edges. Center of wound had pale color. Slight brown drainage on previous dressing. Area covered with xeroform and ABD, secured with tape. Resident had slight pain to area while cleansing and changing dressing. R15's physician updated.

- 11/7/24 at 9:35 a.m., R15's physician ordered R15 to be evaluated in urgent care for R15's right hip wound. FM-A updated and in agreement.

R15's MD/Nursing communication dated 11/7/24, identified a nursing concern related to a "wound right hip 10/19/24. Hot pack". An order was received for Medi pore tape (hypoallergenic tape that is soft and breathable to reduce the risk for skin sensitivity), xeroform non-occlusive (a sterile, non-adhering permeable dressing consisting of absorbent, fine-mesh gauze impregnated with a

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F 580	Continued From page 21 water-in-oil emulsion blend), ABD pad (a large wound dressing). R15's nursing progress note dated 11/7/24 at 11:46 a.m., identified R15 seen in urgent care due to wound to right hip. Orders as follows: Medi pore tape, xeroform nonocclusive, ABD pad; if dressing starts to become saturated then increase dressing change to twice a day. Orders updated in Treatment Administration Record (TAR). Resident referred to wound clinic for further care of wound. R15's physician progress note dated 11/8/24, identified R15's Wound #1 Right Hip was a chronic Full Thickness Burn, thermal (3rd degree) acquired on 10/19/2024 and had received a status of Not Healed. Initial wound encounter measurements are 4.18 cm length x 3.68cm width x 0.01 cm depth. Necrotic adipose (a condition that occurs when fatty tissue is damaged, leading to the death of the fat cells) was exposed. No tunneling has been noted. No sinus tract was noted. No undermining was noted. There was a moderate amount of serosanguineous drainage noted which had a Strong odor. R15 reported a wound pain of level 4/10. The wound margin was attached Wound bed has no granulation (a sign of wound healing) (new connective tissue), no slough (dead tissue within the wound that can impede healing), no epithelialization (new cells) but had eschar (dead tissue that sheds or falls off from the skin). During a telephone interview on 1/28/25 at 1:30 p.m., registered nurse (RN)-A stated she notified R15's physician by making a note in the rounding book. However, RN-A stated she was unaware of when R15's physician would have been rounding	F 580		

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F 580	Continued From page 22 at the facility. During an interview on 1/28/25 at 2:46 p.m., RN-B stated she was the acting director of nursing (DON) on 10/19/24 when R15 received a burn to R15's right hip. RN-B was notified of the burn on 10/21/24, but she did not notify R15's physician until 11/7/24 when there was concern about a potential infection. A joint interview was conducted with the DON and RN-D on 1/28/25 at 4:20 p.m. The DON and RN-D stated R15's physician should have been notified immediately to ensure appropriate care and treatment of the burn to prevent worsening and to promote healing. During a telephone interview on 1/29/25 at 3:06 p.m., physician (DR)-A stated, typically for injuries, DR-A would expect to be notified in a day or two. For a burn, DR-A would more than likely have ordered a Silvadene (Silver sulfadiazine is an antibiotic. It fights bacteria and yeast on the skin. Silvadene (for the skin) is used to treat or prevent serious infection on areas of skin with second- or third-degree burns.) dressing and instruct to continue to monitor the wound. R15's delay of evaluation and treatment did not ease the healing process; however, DR-A would not say if it worsened the wound because DR-A did not evaluate the wound prior to 11/7/24. R29: R29's quarterly MDS dated 10/31/24, identified R29 had intact cognition. R29 required moderate assistance to dress lower body and with grooming. R29 was independent with transfer and ambulation. R29 had experienced one fall with injury since her last assessement period.	F 580		

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F 580	Continued From page 23 Diagnoses included fibromyalgia, chronic pain syndrome, age related osteoporosis, moderate stage rheumatoid arthritis of multiple sites, and intervertebral disc degeneration, lumbar region with back pain. R29's care plan with revision date 11/6/24, identified R29 was at risk for falls related to weakness, and impaired mobility. R29 was independent with ambulation with a walker. R29 receivied anticoagualant therapy with a goal to be free from discomfort or adverse reactions related to anticoagulant use. R29's progress notes were reviewed and identified the following: - 11/29/24, R29 fell when trying to hang up a shirt in her closet. Her walker started to roll away and she became weak and fell, hitting her right side of her body on the floor. A physical assessment was completed, and family was notified. However, failed to identify if the physician was notified. -11/30/24, a large, swollen area and bruise 25 cm by 28 cm was noted on R29's right hip as a result of her fall the previous day. Ice packs were applied. - 12/2/24, R29 complained of not feeling well and questioned if she had a sinus infection. R29 agreed to be seen in urgent care the following day. R29 also complained of pain in right hip and was given an ice pack -12/3/24, R29 returned from urgent care. R29 had been assessed for complaints of respiratory illness. A hip X-ray had also been completed which was negative.	F 580		

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F 580	Continued From page 24 A Office Visit report dated 12/3/24, identified R29 was seen in clinic for symptoms of cough, nasal congestions and sinus pressure. R29 reported a fall 11/29/24, in which she landed on her right side. R29 complained of pain and reported a large lump on her right hip. On assessment the right hip had large swelling and a large hematoma with pain over the lateral hip. R29 was able to bear weight. A hip Xray was completed with negative findings. R29 was to use heat or ice in 20-minute intervals and return if symptoms worsened. When interviewed on 1/29/25, at 10:44 a.m. R29 stated she had fallen on around the beginning of December in front of her closet. R29 was reaching up for something in the closet and fell. R29 had a bruise that went from her hip to her bruise and still had the lump over the right hip. Pointed to a small, elevated area over her right hip, visible through her pants and stated it still hurt in her groin area. She went to the clinic because she had not been feeling well and they had noticed the bruise and took and Xray which turned out to be ok. When interviewed on 1/30/25, at 3:16 p.m. DON stated she was unable to find an investigation related to the fall with injury. R29's bruise and injury had been monitored on the treatment administration record and/or on her care plan, however, R29's physician had not been notified of the incident, nor was R29 evaluated by the provider. The DON stated it was the facility's general practice to notify the provider of all resident falls. The DON was unable to find documentation R29's primary provider had been notified of her fall with injury on 11/29/24.	F 580		

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F 580	Continued From page 25 The facility policy Incidents and Accidents dated 1/2025, identified it was the facility's policy to utilize point click care to report, investigate and review any accidents or incidents that occurred. The nurse would contact the resident's provider to inform them of the incident/accident and report any injuries or other findings, and obtain orders, if indicated.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		2/28/25

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F 609	Continued From page 26 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report a burn that resulted from the inappropriate use of a hot pack to the state agency (SA) for 1 of 1 resident (R15) reviewed for wound care. Findings include: The Rester's Choice Gel Pack undated manufacturer's instructions directed the following: Clean microwave before use. Gel pack must be at room temperature before microwave use. Distribute gel evenly in pack and place in microwave. Before removing gel pack from microwave, check for leakage. If leakage occurred, wait for the gel pack to cool down and discard. Check for desired temperature (temperature will continue to rise slightly). If pack is too hot, let it cool until temperature is acceptable. If additional heat is desired, return to microwave and heat in 5 second increments. DO NOT overheat. Excessive heating might cause pack to rupture and leak. Place it in the provided pouch. Apply to affected area and use the strap as necessary to hold in place. Store at room temperature for future hot therapy use. Do not apply cold/hot therapy for more than 20 minutes. Microwave Heating Time: Since the power of microwave ovens may differ from one microwave to another, the best heating time should be tested when first used at each microwave: a.) Heat the gel pack for 30 seconds b.) Check temperature every 5 seconds When the desired temperature is reached and evenly distributed, that's the heating time that	F 609	Failure to immediately report to the SA any accidents that have the potential to be the result of abuse/neglect places all residents at increased risk for abuse and neglect that could result in mental anguish or physical harm. During the annual survey conducted on 01/27/2025-1/30/2025 the state agency became aware of a burn to R15's right thigh. In an attempt to identify any accidents that have gone unreported, an audit was completed by the Director of Nursing of all accident reports for the past 30 days with no further abuse reporting indicated. Education will be provided to all staff at all-staff meetings held between the dates of 2/24/25 and 2/28/25. Education will include a review of circumstances that require reporting to the SA including appropriate timeframes and practice guidelines. The Director of Nursing Services or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriately to the SA. Missed notifications identified will be completed upon identification with follow up by the DON with person responsible for initiating the initial report. Results of audits will be brought to the	

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F 609	Continued From page 27 should be used at the current microwave oven. - Caution/Warnings: Individuals with circulatory or diabetes issues should consult a physician before use. Do NOT lean or sit on pack. Unattended use of gel pack by elderly or incapacitated individuals is dangerous; monitor for insensitivities to product temperature. R15's quarterly Minimum Data Set (MDS) dated 10/10/24, identified R15 had a moderate cognitive impairment and diagnoses that included weakness, type 2 diabetes, and chronic kidney disease. R15 required partial to moderate assistance to roll her body left and right and was at risk for pressure ulcers. R15's nursing progress note dated 10/19/24 at 12:05 p.m., identified a nursing assistant (NA) noted a blister measuring 4 centimeters (cm) by 1.5 cm on R15's right hip related to heat pack being applied. Heat pack was not overly warm, but R15 did fragile skin and did lay on the heat pack which may have contributed to blister occurring. R15 denied pain in hip or blister. The blister was left open to air. Family member (FM)-A was informed and stated R15's skin was very thin and likely blistered easily. R15's physician progress note dated 11/8/24, identified R15's wound on R15's right hip was a chronic Full Thickness Burn (also called a third-degree burn. This type of burn involved all of the layers of skin and sometimes the fat and muscle tissue under the skin. Burned areas may be black, brown or white. The skin may look leathery. Third-degree burns can destroy nerves, so there may be little or no pain) that was acquired on 10/19/24 and had not healed. Initial wound encounter measurements are 4.18 cm	F 609	QAPI meeting scheduled for 4/2025 for determination of further auditing needs.	

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	245592	A. BUILDING _____ B. WING _____	C 01/30/2025

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F 609	Continued From page 28 length by 3.68cm width by 0.01 cm depth. Necrotic adipose (Fat necrosis is a condition that occurs when fatty tissue is damaged, leading to the death of fat cells (also known as adipose cells)) was exposed. No tunneling was noted. The patient reports a wound pain of level 4/10. The wound margin was attached, and the wound bed had no granulation (new connective tissue), slough (yellowish or tan colored material) or epithelization (wound closure) but did exhibit eschar (a hardened, dry, black or brown dead tissue, forms a scab-like covering over deep wounds, such as severe burns or ulcers). An investigation into causative factors and analysis of R15's burn was requested and was not received. During a telephone interview on 1/28/25 at 1:30 p.m., registered nurse (RN)-A stated she put the hot pack on R15. On 10/19/24, R15 fell during shift change. R15 was assisted back to bed but complained of right hip pain. RN-A had not been educated on the gel pack heating instructions nor had RN-A read the manufacturer's instructions on the back on the gel pack. RN-A heated a gel pack in the microwave for "maybe" 30 seconds, wrapped the gel pack in a hand towel, placed the gel pack on R15's right hip and positioned R15 on her right side so that R15 was lying on the gel pack. Later that morning, (approximately 30 minutes) R15 had a shower and RN-A performed a routine weekly skin assessment on R15 when RN-A discovered the "reddened area" that resulted in a burn on R15's right hip. However, RN-A stated she did not report the burn to the state agency (SA) because she wasn't sure if the reddened area wouldn't go away.	F 609		

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F 609	Continued From page 29 During an interview on 1/28/25 at 2:46 p.m., RN-B stated she was informed of R15's burn on 10/21/24, however, a report to the SA was not discussed nor completed. "I just didn't think of it." During an interview on 1/28/25 at 4:20 p.m., with the director of nursing (DON) and the RN-D, the DON stated she started her role on 11/25/24 and was unaware of the circumstances of R15's right hip burn. The report to the SA should have been filed. RN-D stated she was also unaware of the circumstances of R15's burn was a serious concern that showed lack of assessment and follow through to prevent a burn from happening again. The facility policy Abuse Prevention and Reporting revised 1/2025, identified all cases of suspected abuse/neglect/exploitation must be reported to authorities immediately, after forming a suspicion if cause of suspicion did not result in serious bodily injury, to the Administrator, Department Manager, or the Administrator's designee. The definition of "immediately", means as soon as possible, but no later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours. A person (including an employee, volunteer or other person) associated with the facility, who reasonably believes or who knows of information that would cause a person to believe that the health or welfare of a resident of the facility has been, is or will be adversely affected by abuse or neglect by any person shall, as soon as possible, report the information supporting the belief to the Minnesota Department of Health, or the appropriate healthcare regulatory agency, by	F 609		

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F 609	Continued From page 30 telephone, in writing, or by personal visit. Reports of abuse, neglect, misappropriation of property, and exploitation should be made immediately to the Administrator or his/her designee. During normal business hours, notify the Administrator or Director of Nursing. During non-normal business hours, notify the on-call RN (responsible to submit reports to MDH during non-normal business hours) and notify the administrator and director of nursing (this may be done by phone, answering machine, voicemail, or text message).	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to investigate a burn that resulted from the inappropriate use of a hot pack for 1 of	F 610	Failure to conduct a thorough investigation for allegations or reports of abuse/neglect places all residents at risk	2/28/25

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F 610	Continued From page 31 1 resident (R15) who was reviewed for wound care. Findings include: Rester's Choice Gel Pack manufacturer's instructions directed the following: Clean microwave before use. Gel pack must be at room temperature before microwave use. Distribute gel evenly in pack and place in microwave. Before removing gel pack from microwave, check for leakage. If leakage occurred, wait for the gel pack to cool down and discard. Check for desired temperature (temperature will continue to rise slightly). If pack is too hot, let it cool until temperature is acceptable. If additional heat is desired, return to microwave and heat in 5 second increments. DO NOT overheat. Excessive heating might cause pack to rupture and leak. Place it in the provided pouch. Apply to affected area and use the strap as necessary to hold in place. Store at room temperature for future hot therapy use. Do not apply cold/hot therapy for more than 20 minutes. Microwave Heating Time: Since the power of microwave ovens may differ from one microwave to another, the best heating time should be tested when first used at each microwave: a.) Heat the gel pack for 30 seconds b.) Check temperature every 5 seconds When the desired temperature is reached and evenly distributed, that's the heating time that should be used at the current microwave oven. - Caution/Warnings: Individuals with circulatory or diabetes issues should consult a physician before use. Do NOT lean or sit on pack. Unattended use of gel pack by elderly or incapacitated individuals is dangerous; monitor for insensitivities to product temperature.	F 610	for additional or continued abuse/neglect. During the annual survey dating 1/27/2025-1/30/2025 Rester's Choice Gel Packs were removed from the facility. Around 12/13/25 McKesson instant hot packs were ordered and implemented including instruction being provided to nursing staff to be aware of manufacturer's instructions of use which includes picture instructions on individual packages to ensure proper use. Internal investigation surrounding the incident was completed the week of 1/27/25-1/30/25. This resulted in findings of missed opportunities for proper first aid and assessment following a fall, notification of physician, delayed identification of a wound and initiation of proper wound care. The facility policy Abuse Prevention and Reporting was reviewed on 1/21/25 with no revisions being made. Investigations needing to be completed based on audits of records for missed reporting opportunities will be completed as indicated. Between the dates of 2/24/25 and 2/28/25, the DON will provide all nursing staff with education addressing circumstances that require reporting for timely investigation, and their responsibilities related to investigations. Additional education will be provided to nursing staff at an all staff meeting to include expectations in regard to use of instant heat packs, proper first aid and assessment following falls, wound identification and treatment, and timely notification to providers.	

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F 610	Continued From page 32 R15's quarterly Minimum Data Set (MDS) dated 10/10/24, identified R15 had a moderate cognitive impairment and diagnoses that included weakness, type 2 diabetes, and chronic kidney disease. R15 required partial to moderate assistance to roll her body left and right and was at risk for pressure ulcers. R15's nursing progress note dated 10/19/24 at 12:05 p.m., identified a nursing assistant identified a blister measuring 4 centimeters (cm) by 1.5 cm on R15's right hip related to heat pack being applied. Heat pack was not overly warm, but R15 did fragile skin and did lay on the heat pack which may have contributed to blister occurring. R15 denied pain in hip or blister. The blister was left open to air. Family member (FM)-A was informed and stated R15's skin was very thin and likely blistered easily. R15's physician progress note dated 11/8/24, identified R15's wound on R15's right hip was a chronic Full Thickness Burn (also called a third-degree burn. This type of burn involved all of the layers of skin and sometimes the fat and muscle tissue under the skin. Burned areas may be black, brown or white. The skin may look leathery. Third-degree burns can destroy nerves, so there may be little or no pain) that was acquired on 10/08/24 and had not healed. Initial wound encounter measurements are 4.18 cm length by 3.68cm width by 0.01 cm depth. Necrotic adipose (Fat necrosis is a condition that occurs when fatty tissue is damaged, leading to the death of fat cells (also known as adipose cells)) was exposed. No tunneling was noted. The patient reports a wound pain of level 4/10. The wound margin was attached, and the wound bed	F 610	Audits will be conducted on accident and incident reports involving falls and new skin concerns for a period of 6 consecutive weeks. This will include reviewing incidents reports and documentation for evidence of proper assessment and treatment after injury, notification to provider and state agency, wound identification and timely treatment initiation. Noncompliance with expectations will be identified and reeducation will be conducted upon identification with staff responsible. Additionally, use of facility provided instant heat packs will be observed at a rate of 5x/week for 4 weeks to ensure appropriate and safe use to minimize risk for skin injury and burns. Results of audits will be reviewed and QAPI meeting to be held 4/2025 for determination of ongoing auditing needs.	

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F 610	Continued From page 33 had no granulation (new connective tissue), slough (yellowish or tan colored material) or epithelization (wound closure) but did exhibit eschar (a hardened, dry, black or brown dead tissue, forms a scab-like covering over deep wounds, such as severe burns or ulcers). During a telephone interview on 1/28/25 at 1:30 p.m., registered nurse (RN)-A stated she put the hot pack on R15. On 10/19/24, R15 fell during shift change. R15 was assisted back to bed but complained of right hip pain. RN-A had not been educated on the gel pack heating instructions nor had RN-A read the manufacturer's instructions on the back on the gel pack. RN-A heated a gel pack in the microwave for "maybe" 30 seconds, wrapped the gel pack in a hand towel, placed the gel pack on R15's right hip and positioned R15 on her right side so that R15 was lying on the gel pack. Later that morning, (approximately 30 minutes) R15 had a shower and RN-A performed a routine weekly skin assessment on R15 when RN-A discovered the "reddened area" that resulted in a burn on R15's right hip. RN-A disposed of the gel packs because she believed R15's was caused by a defective gel pack; however, RN-A did not review the manufacturer's instructions to verify the gel pack had been used correctly. RN-A provided verbal direction to the other nursing staff; however, no documentation of that direction was done. Additionally, RN-A did not report the incident to RN-B (who was acting director of nursing at the time) until 10/21/24. During an interview on 1/28/25 at 2:46 p.m., RN-B stated she was the acting director of nursing on 10/19/24 when R15 received a burn to R15's right hip. RN-B stated R15 had fallen and staff had applied a hot pack to R15's right hip for	F 610		

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F 610	Continued From page 34 comfort. R15 was laying directly on the hot pack and R15's skin was burned. RN-B stated she wasn't notified of the burn until 10/21/24. The burn was discussed in the morning interdisciplinary meeting (IDT) and it was decided the facility would obtain new gel packs because RN-A had thrown the gel packs away because RN-A believed the gel packs to be defective. RN-B stated no investigation to determine if the gel pack was used appropriately, if the gel pack should have been used for R15 who was a diabetic, if the nursing staff were aware of the gel pack heating instructions, and/or any other resident who had received a burn from the gel packs. RN-B stated a thorough investigation should have been conducted to prevent further harm to R15 or harm to any other resident. The facility's IDT (interdisciplinary team) minutes dated 10/22/24, identified "Order new ice/hot pack" but failed to identify and investigation into the causeative factors of R15's burn. The facility's IDT minutes dated 10/23/24, identified "new hot packs/cold packs purchased" but failed to identify R15's burn. The facility's purchasing order dated 10/22/24, identified microwavable heating pads were orders The facility's purchasing order dated 12/19/24, identified the purchase of 2 boxes of McKesson Hot Compress. During an interview on 1/28/25 at 4:20 p.m., with the director of nursing (DON) and RN-D, the DON stated she started her role on 11/25/24 and was unaware of the circumstances of R15's right hip burn. A thorough investigation should have been	F 610		

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F 610	Continued From page 35 conducted to ensure the safety of the residents. RN-D stated she was also unaware of the circumstances but R15's burn was a serious concern that showed lack of assessment and follow through to prevent a burn from happening again. The facility policy Abuse Prevention and Reporting revised 1/2025, identified at the administrator or his/her designee will then begin the investigation. As part of the investigation, the affected resident(s) will be interviewed, staff and other witnesses will be interviewed, circumstances leading up to the incident will be evaluated, employees/persons accused of abuse will be investigated, and policies and procedures will be reviewed.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medications section of the Minimum Data Set (MDS) was accurately coded for 1 of 1 resident (R15) reviewed for MDS accuracy. Findings include: R15's significant change Minimum Data Set (MDS) dated 11/21/24, identified R15 had a moderate cognitive impairment and diagnoses that included Type 2 Diabetes. R15 received an insulin injection weekly.	F 641	Failure to complete MDS assessments accurately has the potential to impact resident care planning activities and accuracy of data submitted to CMS. On 2/4/25 a modification of R15's MDS was completed and submitted to CMS to correct the GLP-1 injection coding error. On 2/4/25 an audit of MDS's for all current residents receiving GLP-1 injections was conducted by the corporate RN to ensure GLP-1 injections had not been coded on the MDS as insulin. During the audit no other findings of miscoding GLP-1	2/28/25

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F 641	Continued From page 36 R15's Order Summary Report dated 6/20/23, identified R15 received Trulicity (an antihyperglycemic - glucagon-like peptide-1 (GLP-1) receptor agonists) (used with a proper diet and exercise program to control high blood sugar in people with type 2 diabetes) subcutaneous solution pen-injector 3 milligram (mg)/0.5 milliliter (ml). Inject 3 mg subcutaneously in the morning every Thursday related to type 2 diabetes. During an interview with the registered nurse (RN)-D on 1/29/25 at 11:32 a.m., RN-D stated she was assisting with completing resident MDS while the facility's MDS nurse was out of the facility on medical leave. RN-D stated Trulicity was not an insulin but a GLP-1 medication to assist in the treatment of type 2 diabetes and, because of that, should be identified as an insulin on the MDS. RN-D stated the MDS was a tool to assist in the resident's individualized plan of care and R15 received an injectable mediation to treat type 2 diabetes once a week. Because of this, RN-D stated R15's MDS was coded correctly. The facility policy Resident Assessment (Minimum Data Set (MDS)) revised 1/2025, identified it was the policy of the facility to conduct initial and periodic standardized assessments of each resident's functional capacity. This will include assessment and evaluation of a resident's needs, strengths, goals, life history, and preferences using the resident assessment instrument (RAI) as specified by CMS. Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2024, identified the steps for assessment included:	F 641	injections as insulin were noted. The facility policy for Resident Assessment was reviewed on 2/21/25 with no modifications being made. RN's who work at the facility will be educated on the expectations of GLP-1 medications not being coded on the MDS as an insulin injection via verbal instruction by 3/1/25. Medical records of all current residents will be audited weekly to identify those who have GLP-1 medications on their medication list. MDS's completed that week will also be reviewed to identify assessments that had been completed for residents identified as having GLP-1 medications. Residents who have GLP-1 medications on their med list and have had an MDS completed that week will be reviewed for accurate coding by the corporate nurse for accurate coding compliance prior to submission. This audit will take place weekly beginning the week of 3/1/25 through 6/1/25 audited Miscoding identified during audits will result in re-education regarding accurate MDS coding with the RN responsible. Results of audits will be shared at the first QAPI meeting following completion for review and determination of further auditing needs.	

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F 641	Continued From page 37 1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Determine if the resident received insulin injections during the look-back period. 3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period. 4. Count the number of days insulin injections were received and/or insulin orders changed.	F 641		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure manufacturer's instructions were followed for the use of a microwave heating of a gel pack, complete a comprehensive assessment of the burn and implement timely interventions to promote the healing of a burn for 1 of 1 resident (R15) reviewed for burns. This resulted in actual harm to R15 who sustained a 3rd degree burn (destroys your first three layers of skin and fatty tissue) from a gel pack.	F 684	Failure to ensure that residents receive treatment and care in accordance with professional standards has the potential to affect all residents residing at the facility. On 2/21/25 date, audit of documented skin concerns for the previous 30 days was conducted to identify residents who may have suffered burns from use of Rester's Choice Gel Packs with no other residents being identified. On 2/24/25,	2/28/25

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F 684	Continued From page 38 Findings include: R15's quarterly Minimum Data Set (MDS) dated 10/10/24, identified R15 had a moderate cognitive impairment and diagnoses that included weakness, type 2 diabetes, and chronic kidney disease. R15 required partial to moderate assistance to roll her body left and right and currently had no wounds. R15's care plan dated 10/16/24, identified R15 was at risk for pain related to spinal stenosis, osteoporosis, weakness, impaired mobility, shoulder pain, spondylolisthesis osteoarthritis, chronic gout, low back pain, and amputation of the second toe of the right foot. Non-pharmacological pain interventions may include rest, reposition, distraction, elevation and ice/warm pack. The care plan directed to update R15's physician with changes. R15's nursing progress notes identified the following: - 10/19/24 at 8:49 a.m., a voicemail was left for family member (FM)-A. R15 was complaining of right hip pain, would note rate pain. As needed (PRN) Tylenol and heat pack applied - 10/19/24 at 12:05 p.m., a nursing assistant (NA) noted a blister measuring 4-centimeter (cm) x 1.5 cm on R15's right hip related to heat pack being applied. Heat pack was not overly warm, but R15 did have fragile skin and did lay on the heat pack which may have contributed to blister occurring. R15 denied pain in hip or blister. Blister left open to air. FM-A informed and stated R15's skin was very thin and likely why it blistered easily.	F 684	R15's care plan was updated to include no use of heat packs d/t fragile skin and conditions that predispose her to burns. All residents will be reviewed for appropriateness of heat packs as treatment for pain by 2/28/25 and those not appropriate for use will have this will be explicitly noted on the residents medical record. This will also be added to the assessment upon admission for new residents on an ongoing basis. On 1/28/25, Rester's Choice Gel Packs were removed from the facility. Around 12/13/25 McKesson instant hot packs were ordered and implemented including instruction being provided to nursing staff to be aware of manufacturer's instructions of use which include picture instructions on individual packages to ensure proper use including for those which heat is not an appropriate treatment and where this information can be found in the medical record. Furthermore, training specific to assessing burns and administering first aid to burns was reviewed using verbal instruction on best practices. Additionally, expectations laid out in the facility policy for Quality of Care was also reviewed with nursing staff. The facility policy for Quality of Care was reviewed on 1/21/25 with no changes being made. Audits of appropriate use of McKessen Instant Hot Packs, assessing burns and first aid will be conducted at a rate of 5/week for 4 weeks across all shifts. Audits will include questions on proper use (including residents who should not use), expectations, and how to respond to	

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	245592	A. BUILDING _____ B. WING _____	C 01/30/2025

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F 684	Continued From page 39 - 10/20/24 at 11:31 a.m., R15's blistered area was leaking clear fluid. The area was cleansed, and an ABD pad placed. The note failed to provide a description including measurements. - 10/23/24 at 11:42 a.m., R15's routine skin check performed this shift. No new skin concerns noted. Dressing to right hip/thigh changed. Scant amount of serous (clear to light yellow) fluid noted on old dressing. Cleansed and new dressing applied. Tolerated well. Area has no odor or signs/symptoms of infection. - 10/23/24 at 9:51 p.m., R15's dressing to right thigh changed due to previous dressing being soiled. Moderate amount of serous fluid noted on old dressing. No odor noted. Area cleansed with normal saline, and dressing changed per treatment record order. Tolerated well. - 10/26/24 at 3:00 p.m., Telfa (a non-absorbent and non-adhering dressing) and an ABD applied to right outer hip blister/wound. The outer edges of area were red in color and measure 7.5 cm x 4.5 cm, this was area on entire wound. Blister was intact and fluid filled. Resident had no complaints of pain within that area and tolerated dressing change well. - 11/4/24 at 3:27 p.m., R15's skin assessment was completed: 8 cm x 5.5 cm area to right hip that was previously a fluid filled blister in evolution. Skin remained intact. Peri wound was reddened. No warmth noted. Wound edges are smooth. Area was dry and flaky skin noted. Darken discoloration noted to right posterior and left anterior edges. Center of wound had pale color. No drainage to area. Area covered with	F 684	suspected burns including accurate and timely assessment and first aid treatment. Results of audits will be brought to QAPI for review and determination of further auditing needs	

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F 684	Continued From page 40 Xeroform and ABD, secured with tape. R15 had no complaints of pain to area. Will change dressing to area daily. - 11/5/24 at 11:22 a.m., a new dressing applied to right thigh due to old dressing falling off. No drainage noted coming from area, no odor noted. Peri wound reddened; no warmth noted. Area where blister was dark in color. Dressing changed per orders. R14 tolerated well. - 11/7/24 at 7:56 a.m., a 7 cm x 5 cm area to right hip that was previously a fluid filled blister in evolution. Skin remains intact. Peri wound was reddened. No warmth noted. Wound edges were smooth. Area was dry and flaky skin noted. Darken discoloration noted to right posterior and left anterior edges. Center of wound had pale color. Slight brown drainage on previous dressing. Area covered with Xeroform and ABD, secured with tape. R14 had slight pain to area while cleansing and changing dressing. R15's physician updated. - 11/7/24 at 9:35 a.m., R15's physician ordered R15 to be evaluated in urgent care for R15's right hip wound. FM-A updated and in agreement. - 11/7/24 at 11:46 a.m., R15 was seen in urgent care due to wound to right hip. Orders as follows: Medi pore tape, Xeroform nonocclusive, ABD pad; if dressing starts to become saturated then increase dressing change to twice a day. Orders updated in Treatment Administration Record (TAR). Resident referred to wound clinic for further care of wound. R15's medical record lacked a comprehensive assessment for R15's burn along with	F 684		

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F 684	Continued From page 41 interventions implemented. R15's MD/Nursing communication dated 11/7/24, identified a nursing concern related to a "wound right hip 10/19/24. Hot pack". An order was received for Medi pore tape (hypoallergenic tape that is soft and breathable to reduce the risk for skin sensitivity), xeroform non-occlusive (a sterile, non-adhering permeable dressing consisting of absorbent, fine-mesh gauze impregnated with a water-in-oil emulsion blend), ABD pad (a large wound dressing). R15's physician progress note dated 11/8/24, identified R15's wound was a chronic Full Thickness Burn, thermal (3rd degree) acquired on 10/19/24 and had received a status of not healed. Initial wound encounter measurements were 4.18 centimeters (cm) length x 3.68 cm width x 0.01 cm depth. Necrotic adipose (a condition that occurs when fatty tissue is damaged, leading to the death of the fat cells) was exposed. No tunneling was noted. No sinus tract was noted. No undermining was noted. There was a moderate amount of serosanguineous (light pink, watery fluid) drainage noted which had a strong odor. R15 reported a wound pain of level 4/10. The wound margin was attached. Wound bed has no granulation (a sign of wound healing) (new connective tissue), no slough (dead tissue within the wound that can impede healing), no epithelialization (new cells) but had eschar (dead tissue that sheds or falls off from the skin). R15's Order Summary Report identified the following: -10/19/24, Nursing order to monitor 4 cm x 1 .5 cm blister to right hip two times a day. Use ice	F 684		

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F 684	Continued From page 42 pack if causing discomfort. - 10/24/24, Nursing order to monitor 4 cm x 1 .5 cm blister to right hip. Change dressing every 3 days two times a day and as needed (PRN). Cleanse with saline and apply ABD (a large wound dressing) with tape - 11/7/24, Physician order to dressing to right hip - cleanse with saline, pat dry, apply Xeroform (a sterile, non-adhering permeable dressing consisting of absorbent, fine-mesh gauze impregnated with a water-in-oil emulsion blend) and cover with ABD, secure with Medi pore (soft cloth surgical tape, this is a breathable, gentle, conformable tape that comes in easy tear, perforated rolls) tape one time a day. R15's significant change Minimum Data Set (MDS) dated 11/21/24, identified R15 had a burn. R15's wound clinic notes dated 11/8/24 - 1/28/25, identified R15 had received consistent wound care since the referral and R15's wound was in the process of healing. During a telephone interview on 1/28/25 at 9:48 a.m., FM-A stated R15 had a fall back in October 2024 and received no injuries, but did receive a burn to R15's right hip from a hot pack. FM-A stated nursing did tell FM-A right away and said either the hot pack was "faulty or they left it on too long." Nursing made it sound like it wasn't really a big deal and FM-A spoke with R15 every evening and R15 didn't say anything about it. Then, a few weeks later, FM-A was told R15 needed to be seen by a wound specialist. Nursing told FM-A they disposed of all the hot packs. FM-A stated she didn't know if nursing didn't think it was a big deal, but FM-A would have liked to be updated before being told about the wound specialist.	F 684		

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F 684	Continued From page 43 "Maybe we could have done something sooner and it wouldn't have gotten so bad." During a telephone interview on 1/28/25 at 10:43 a.m., registered nurse (RN)-C stated she was aware of the burn but was not working when it occurred. RN-C could not say what first aid was provided to R15, but R15 was being followed by wound care. RN-C stated she was told to not use the hot packs because they were unaware of the feature that would make gel packs so hot. RN-C believed the gel packs were discontinued. During a telephone interview on 1/28/25 at 1:30 p.m., RN-A stated she put the hot pack on R15. On 10/19/24, R15 fell during shift change. R15 was assisted back to bed but complained of right hip pain. RN-A had not been educated on the gel pack heating instructions nor had RN-A read the manufacturer's instructions on the back on the gel pack. RN-A heated a gel pack in the microwave for "maybe" 30 seconds, wrapped the gel pack in a hand towel, placed the gel pack on R15's right hip and positioned R15 on her right side so that R15 was lying on the gel pack. Later that morning, (approximately 30 minutes) R15 had a shower and RN-A performed a routine weekly skin assessment on R15 when RN-A discovered the "reddened area" that resulted in a burn on R15's right hip. RN-A did not apply ice or cool water and left R15's burn open to air. RN-A stated she was unaware of when R15's physician would have been rounding at the facility but did not seek medical attention for R15 because "I thought it might go away." The undated Rester's Choice Gel Pack manufacturer's instructions directed the following: Clean microwave before use. Gel pack must be	F 684		

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F 684	Continued From page 44 at room temperature before microwave use. Distribute gel evenly in pack and place in microwave. Before removing gel pack from microwave, check for leakage. If leakage occurred, wait for the gel pack to cool down and discard. Check for desired temperature (temperature will continue to rise slightly). If pack is too hot, let it cool until temperature is acceptable. If additional heat is desired, return to microwave and heat in 5 second increments. DO NOT overheat. Excessive heating might cause pack to rupture and leak. Place it in the provided pouch. Apply to affected area and use the strap as necessary to hold in place. Store at room temperature for future hot therapy use. Do not apply cold/hot therapy for more than 20 minutes. Microwave Heating Time: Since the power of microwave ovens may differ from one microwave to another, the best heating time should be tested when first used at each microwave: a.) Heat the gel pack for 30 seconds b.) Check temperature every 5 seconds When the desired temperature is reach and evenly distributed, that's the heating time that should be used at the current microwave oven. During an interview on 1/28/25 at 2:46 p.m., RN-B stated she was the acting director of nursing (DON) on 10/19/24, when R15 received a burn to R15's right hip. RN-B stated R15 had fallen, and staff applied a hot pack to R15's right hip for comfort. R15 was lying directly on the hot pack and R15's skin was burned. RN-B stated she was notified of the burn on 10/21/24, during the morning IDT meeting, but she did not notify R15's physician until 11/7/24, when there was concern about potential infection. RN-B stated she did not assess R15's wound until 11/7/24, because nursing staff had completed skin	F 684		

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F 684	Continued From page 45 assessments. RN-B stated she did not evaluate nor analyze R15's burn to determine if the gel pack was used according to manufacturer's instructions and/or if any other diabetic residents had used the gel packs During an interview on 1/28/25 at 4:04 p.m., licensed practical nurse (LPN)-F stated R15's burn was caused by a hot pack, and LPN-F wasn't working when it happened. LPN-F stated she had used the hot packs many times. It's always a resident's choice if they want to use a hot or cold pack and LPN-F "thought" they could be left on for 30 minutes to an hour. If a burn happened when LPN-F was working, LPN-F would immediately try to cool off the burn with ice to try to lessen the burn; then would call the RN on-call for further direction. A joint interview was conducted with RN-D, who was the facility's corporate nurse, and director of nursing (DON) on 1/28/25 at 4:20 p.m. The DON and RN-D both stated they were not aware of the circumstances surrounding R15's burn. The DON stated she "overheard" nurses talking about microwaving gel packs. The DON stated she told the nurses microwaving gel packs was not advisable and ordered the McKesson Hot Compresses on 12/19/24. However, the DON stated she did not question the nurses further and was unaware R15's wound was caused by a gel pack. "We were talking about Best Practice." The DON stated she verbally educated the nurses regarding the McKesson Hot Compress during report at shift changes but had done no formal education. The DON stated staff that worked casually would need to rely on other staff to tell them. DON stated staff were expected to assess, monitor, treat and document wounds to promote	F 684		

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F 684	Continued From page 46 healing. RN-D stated the incident was a serious concern that showed lack of assessment and lack of follow through to prevent this from occurring again. During a telephone interview on 1/29/25 at 3:06 p.m., physician (DR)-A stated, typically for injuries, DR-A would expect to be notified in a day or two. For a burn, DR-A would more than likely have ordered a Silvadene dressing ((Silver sulfadiazine) is an antibiotic. It fights bacteria and yeast on the skin. Silvadene (for the skin) is used to treat or prevent serious infection on areas of skin with second- or third-degree burns) and instruct to continue to monitor the wound. R15's delay of evaluation and treatment did not ease the healing process; however, DR-A would not say if it worsened the wound because DR-A did not evaluate the wound prior to 11/7/24. During an interview on 1/30/25 at 8:49 a.m., the DON and RN-D stated R15's burn should have been thoroughly investigated to ensure equipment was used according to manufacturer's instructions, if staff were aware of how to use the gel pack and to determine which residents with circulatory problems or diabetes were involved to ensure no other residents were or could be harmed. A facility first aid policy was requested but not received. A facility wound monitoring policy was requested but not received A facility policy/procedure regarding the Rester's Choice gel pack was requested but not received.	F 684		

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F 684	Continued From page 47 The American Burn Association's First Aid for Minor Burns direction dated 2020, identified the following: Stop the burning process: - cool with burn with running cool (not cold) water for at least 5 minutes. Sterile water not necessary. - Remove all jewelry, watches, rings, and clothing around the burned area as soon as possible. - Administer an over-the-counter pain reliver such as ibuprofen or acetaminophen for pain control. Follow the directions on the label. Consult a physician or health care provider if pain is not relieved. - Cover the burn with a sterile gauge bandage or clean cloth. Wrap the burned area loosely to avoid putting too much pressure on the burn tissue. - Minor burns will usually heal without further treatment. - For a small area burn (less than 1% or the size of the person's hand), apply soothing lotions that contain aloe vera to a burned area to help relieve the pain and discomfort. - Seek medical attention if there is a persistent fever not relieved by medication or redness that may extend beyond the border of the burn or pain is not controlled by ibuprofen or acetaminophen. - Drink plenty of fluids (electrolyte-containing solutions such as Gatorade) if the person appears to be dehydrated. Do not apply ice - this may further damage to the skin. Do not over cool! If victim starts to shiver, stop the cooling process. Do not use any butter, ointments, or other home remedies on the burn. Such substances may trap the heat in the tissue and makes the burn worse. Do not break any blisters - leave intact. Blisters may rupture over time - this is normal. Do not delay seeking medical attention if the burn is larger than the size	F 684		

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F 684	Continued From page 48 of the victim's hand.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed comprehensively assess a pressure ulcer and implement interventions to promote healing for 1 of 2 residents (R14) reviewed for wound care. Findings include: R14's quarterly Minimum Data Set (MDS) dated 1/8/25, identified R14 had a severe cognitive impairment and diagnoses that included dementia, anorexia, and chronic kidney disease. R14 was at risk for pressure ulcers but had no current pressure ulcers. R14's Braden Scale for Predicting Pressure Sore Risk dated 1/7/25, identified R14 was at risk for	F 686	Failure to assess pressure ulcers and develop treatment plans to promote healing as the potential to place all residents at risk for delayed healing and poor outcomes related to pressure ulcers. On 2/17/25 date, an assessment of the area on R14 s toe by the PCP determined the area of concern to be healed. On 2/21/25, an audit of all wounds was conducted to ensure proper staging, documentation and treatment was in place. This audit consisted of review of 4 residents for wounds with updates being made to 2 residents treatment plans. A review of the facility policy for Skin Care was reviewed and had no changes made. Education to all nursing staff will be	2/28/25

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F 686	Continued From page 49 pressure ulcers. R14's care plan revised 1/13/25, identified R14 was a risk for skin breakdown related to impaired mobility, incontinence, low adipose tissue and impaired cognition. Staff were directed to perform the following: assist R14 to turn/reposition at least every 2-3 hours when up in her wheelchair and all-night rounds, barrier cream will be applied as needed, Braden scale to be completed per facility policy, bruises would be observed at least weekly until healed, pressure relieving mattress and wheelchair cushion, skin tears would be observed at least daily until healed, skin would be observed during cares, staff to report any areas of concern to nurse immediately and weekly skin checks to be completed by licensed staff on bath day. The care plan failed to identify R4's right great toe pressure ulcer or interventions to prevent worsening and/or promote healing. The Paradise resident care sheet dated 1/22/25, failed to identify R14 had a pressure ulcer. R14's nursing progress note(s) identified the following: - 10/22/24 at 11:10 a.m., a nursing assistant (NA) was undressing resident for a shower. While taking socks off R14's feet R14 complained of pain on her right great toe. The NA noticed R14 had an area on the outer side of R14's toe that was bleeding. The NA notified nurse. R14 stated "I don't know what happened. She was taking my socks off and it hurt." Area appears to look like R14 had dry skin stuck to her sock and skin was pulled off when CNA removed her socks. Area measured 1 centimeter (cm) in diameter. Area cleaned and band aide applied. R14's physician	F 686	completed at an all staff meeting between the dates of 2/24/25 and 2/28/25. Training will include a review of the facility policy for Skin Care, wound care protocols, and expectations for documentation, treatment initiation and actions to take if healing stalls. Audits will be completed by the DON or designee 5x/week for 4 weeks. This will include a review of all new skin concerns for current residents and new admissions for appropriate actions in assessment, documentation, development of treatment plan, notification to physician, and communication of interventions. Deficient practice noted during audits will be addressed by DON with licensed nurse for re-education. Results of audits will be brought to QAPI for review and determination of ongoing auditing needs.	

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F 686	Continued From page 50 notified via rounding book, left voicemail for son. - 11/11/24 at 12:35 p.m., identified a disposable adhesive bandage was changed to R14's right great toe. Two small scabs approximately measuring 0.1 cm x 0.1 cm and 0.2 cm x 0.2 cm. Blanchable redness surrounding. No complaints of pain or discomfort. No drainage. A disposable adhesive bandage applied to area. Lotion applied to feet. Shoes removed while R14 lying in bed at this time. - 12/17/24 at 2:57 p.m., R14's skin check completed this shift. A pinpoint small scab to side of R14's right big toe. No other skin concerns. Denies pain. No SOB noted. Lotion to extremities. R14 refused nail care. - 12/24/24 at 1:57 p.m., R14's shower and skin check completed this shift. Skin warm, dry, and intact. Nails trimmed. Lotion applied. No new skin concerns currently. - 1/7/25 at 10:30 a.m., R14's skin assessment was completed. Noted to have open area to great toe under nail. Area measuring 0.5 cm x 0.6 cm. Area was darkened blood tinged. Area around toe was inflamed, reddened. Was not warm to touch. Foot was dry and flaky. R14 offered pain upon assessment. Area cleansed and protective dressing applied. - 1/12/25 at 12:24 p.m., identified R14's skin assessment was completed. Previously open area to under right great toenail has now scabbed over. Scabbed area measuring 0.5 cm x 0.6 cm. Area was dry and intact. Toe was no longer inflamed. Was not reddened, warm to touch, no swelling noted. R14 denied having any pain to	F 686		

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F 686	Continued From page 51 area. Area cleansed and protective dressing applied. Will encourage R14 to remove footwear while in bed. Will continue with current plan of care. - 1/17/25 at 11:29 a.m., identified R14 continued with scabbed area to right great toe measuring 0.5 cm x 0.4 cm. Area was dry and intact. No redness, inflammation, or swelling noted to area. R14 had no complaints of pain or discomfort. Area cleansed and protective dressing applied. Will continue with encouraging R14 to remove shoes while in bed and apply dressing every other day and as needed (PRN). - 1/22/25 at 11:21a.m., identified R14 continued with scabbed area to right great toe measuring 0.5 cm x 0.4 cm. Area was dry and intact. No redness, inflammation, or swelling noted to area. R14 had no complaints of pain or discomfort. Area cleansed and protective dressing applied. Will continue with encouraging resident to remove shoes while in bed and apply dressing every other day and PRN. - 1/28/25 at 2:03 p.m., identified R14's routine skin check performed this shift. No new skin concerns noted. Dressing to right great toe changed per order. No drainage noted to previous dressing. No odor or signs or symptoms of infection. Tolerated well. R14's wound dressing order dated 1/12/25 through 1/14/25, directed staff to apply a right great toe dressing daily: cleanse area with wound wash, pat dry, apply foam dressing, wrap with kerlix and secure with tape R14's wound dressing order dated 1/15/25,	F 686		

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F 686	Continued From page 52	F 686		

directed staff to apply a right great toe dressing every other day and as needed: cleanse area with wound wash, pat dry, apply foam dressing, wrap with kerlix and secure with tape

R14's medical record lacked a comprehensive assessment along with new interventions to promote healing of the pressure area on the right toe.

During an interview on 1/29/25 at 2:06 p.m., NA-A stated R14 did have a sore on her toe but R14 liked to keep her socks on all the time, even when in bed. The nurse put the dressing on the toe, so NA-A did not really know what the wound looked like. "I really don't know more than that."

During an interview on 1/29/25 at 3:22 p.m., NA-B stated R14 did have a "little sore" on her right great toe. NA-B hadn't really seen the wound but "it's just a little thing." NA-B did not know what they nurses were doing for the would other than a dressing.

During an interview on 1/29/25 at 3:24 p.m., licensed practical nurse (LPN)-A stated R14 did have a wound on her right great toe and LPN-A needed to change R14's dressing that evening when R14 was ready for bed. LPN-A stated she really didn't know anything about the wound other than the dressing order, what it was caused from or what the staff were doing to promote healing or prevention worsening.

During an observation on 1/29/25 at 4:22 p.m., registered nurse (RN)-B changed R14's dressing. RN-B wore gloves but did not put on a gown. R14 had two open areas at the base of her right great toenail. The measurements for the first area were

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F 686	Continued From page 53 0.5 cm x 0.4 cm and the second measured 0.3 cm x 0.1 cm. The areas were dry and scabbed. During an interview on 1/29/25 at 4:40 p.m., RN-B stated the wound to R14's right great toe was the same wound that began on 10/22/24. Staff have been doing dressing changes and encouraging R14 to take off her shoes and wear gripper slippers but R14 would refuse the slippers. RN-B stated the wound was caused by R14's toe rubbing on the inside of R14's shoe causing "pressure." RN-B stated R14's wound interventions were passed on to staff verbally during report, but no interventions had been documented besides dressing orders. RN-B stated prior to 1/12/25, staff were using their nursing judgement to apply a dressing but because there was concern for infection on 1/7/25, an "official" dressing order was entered on 1/12/25. RN-B stated consistent weekly documentation had been completed to ensure R14's wound was healing. During an interview on 1/29/25 at 4:44 p.m., the director of nursing stated staff were expected to follow the facility's pressure ulcer protocol. The facility's policy for pressure ulcer was requested but not received. The facility's policy for wound dressing was requested but not received.	F 686		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		2/28/25

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F 697	Continued From page 54 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure as needed pain medications were available to treat acute break through pain for 1 of 2 residents (R27); and failed to respond to request for pain medications for 1 of 2 residents (R29) reviewed for pain management. Findings include: R27: R27's quarterly Minimum Data Set (MDS) dated 10/17/24, identified R27 had severe cognitive impairment and had impaired range of motion in both upper and lower extremities. R27 received both scheduled and as needed pain medications. There were nonverbal sounds and facial expressions of pain observed three to four days per week. R27's Quarterly Pain Assessment dated 12/12/24, identified R27 received scheduled pain medication and PRN pain medication, and having received no non-medication interventions for pain. R27 was unable to answer pain interview questions so a staff assessment for pain was completed. Pain was observed with non-verbal sounds such as crying, whining, gasping or moaning and facial expressions of grimaces, winces, wrinkled forehead, furrowed brow or clenched teeth or jaw and the indicators of pain was noted daily. The quarterly pain assessment failed identify underlying causes or patterns to	F 697	Failure to properly manage pain has the potential to negatively impact the quality of life for all residents residing at the facility. On 12/5/24, R27 was admitted to hospice for assistance with end of life care and pain management. R27 has since passed away. On 1/30/25, R29's order for lidocaine patches was changed to be administered by 9am daily per residents request and preferences. RN-E was educated on expectations on 1/31/25 before being allowed to return to work. Residents receiving scheduled and PRN pain medications were identified through a medical record audit on 2/21/25. A review of the past 14 days for late administrations was conducted on 2/21/25 with late administrations being found for 19 residents. Residents being identified as having received late administrations of pain medications were interviewed, if interview-able, to ensure preferences for medication administration and proper pain management. Adjustments to orders were made to one resident d/t preferences for sleep schedule resulting in frequent late administrations. Non-interview-able residents had further chart review for identification of unmanaged pain with no indication of unmanaged pain being identified. Additionally, on 2/21/25 a meeting was held with the consultant pharmacist to review contents of EKIT and utilization of EKIT contents. When a	

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F 697	Continued From page 55 R27's pain, determine if R27's pain had increased, responses to interventions to prevent or reduce pain, or whether current approaches needed to be reconsiders, revised or supplemented. R27's care plan, with last revision date 12/14/24, identified R27 was at increased risk for pain related to fibromyalgia, polymyalgia rheumatic, osteoarthritis and impaired mobility. A goal was listed R27 would show signs and symptoms of adequate pain relief. Interventions included administer pain medications as ordered, encourage adequate rest periods, non-pharmacological pain interventions to include distraction, reposition, rest, elevation, ice/warm pack and staff were directed to observe for pain at least every shift, using the non-verbal pain scale. R27's Physician Order Summary report dated 1/29/25, identified R27 was ordered acetaminophen 1000 milligrams (mg) three times a day with start date of 1/25/24, as well as acetaminophen 650 mg every four hours as needed with start date 10/31/21. Oxycodone 5 mg every 12 hours as needed was also ordered for severe pain with start date 2/9/24. During interview on 1/28/25, at 8:14 a.m. family member (FM)-A stated the facility's idea of pain management was to give R27 an as needed pain pill. Staff told FM-A R27 was not getting the PRN pain medication every 12 hours and so it did not need to be scheduled. FM-A felt the staff needed to watch for R27's cues that she was in pain. FM-A had been asking the facility to stop applying R27's splints for a long time. R27 had torn ligaments in her joints that made the splints more	F 697	medication is unavailable, the EKIT contents will be utilized per pharmacy procedures to minimize the risk of pain and ensure residents receive continuity of care. The facility policy for pain management and medication administration was reviewed on 1/21/25 with changes made to medication administration policy. Staff who are certified and licensed to pass medications were educated on the facility policies between the dates of 2/24/25 and 2/28/25 at all staff meetings. Education was completed via verbal instruction with an emphasis on proper pain assessment/observation and timeliness of pain medication administration and procedures when medications are not available, including contacting on-call provider and utilization of the EKIT. Audits will be completed via record review for late administrations 5x/week for 4 weeks beginning on 3/15/25. Pain medications noted as being administered late will be identified and the DON or designee will follow up with the resident to assess for unmanaged pain and with the staff to determine barriers to timely administration with further follow up as indicated. Audits of staff knowledge on how and when to utilize the EKIT will be completed by the DON or designee at rate of 5 per week for a period of 4 weeks and will be completed via licensed and TMA staff interview.	

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F 697	Continued From page 56 painful. FM-A stated the facility ran out of R27's as needed pain medication at one point and R27 had to wait a long time for her pain medication, FM-A thought it had taken into late the next day. FM-A removed the hand splints from the facility and the physician did finally order them to be stopped. Once R27 was placed on hospice her pain was managed with a patch and removing the splints. R27 had since passed away. R27's progress notes identified the following: - 11/27/24, staff noted R27 had two doses of her pain medication remaining. Pharmacy was contacted and staff were notified the provider would need to be contacted for refill request, as R27 was out of refills for the oxycodone. Staff also called R27's provider's office to update on need for medication. - 11/28/24, FM-A visited and assisted staff with R27's tub bath. R27 was hollering out during the transfer and bathing process. FM-A was upset R27 did not have her pain medication available and requested a provider be contacted to request an injection for pain relief. Review of available emergency kit medications identified oxycodone with Tylenol was available, however, R27's oxycodone order did not include Tylenol, and the hospitalist would need to be contacted to approve. R27 was laid down in bed and shoulders and knees were rubbed with Voltaren cream (an analgesic). R27 then fell asleep. FM-A took R27's hand splints home with her and notified staff she would return the hand splints to the facility when R27 had her pain medication available. - 11/29/24, at 10:17 a.m. pharmacy was contacted regarding R27's oxycodone refill.	F 697		

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F 697	Continued From page 57 Pharmacy was still waiting refill authorization from the provider. Call placed to provider to notify R27 was out of her pain medication. - 11/29/24, at 3:29 p.m. call was placed to pharmacy for update on R27's need for refill of oxycodone. Pharmacy indicated medication would be delivered this evening. Family updated. R27's November Medication Administration Record 2024, identified acetaminophen 1000 mg was administered three times per day, and PRN oxycodone was administered 20 times during the month of November with pain noted in range from 4 to 10 on a 0 to 10 scale. PRN Tylenol was administered two times on 11/29/24 for pain rated at 5 on a 0 to 10 scale. The PRN oxycodone had been administered on 11/28/24, at 2:58 a.m. and was next administered 11/29/24, at 7:53 p.m. When interviewed on 1/28/25, at 4:12 p.m. registered nurse (RN)-B stated R27 had scheduled Tylenol for pain and staff would allow her to rest in bed when in pain. The oxycodone was effective for R27's pain and the family wanted the medication increased. RN-B instructed staff to assess and use the PRN medication more frequently. RN-B faxed R27's primary provider with request to increase the frequency of R27's oxycodone, but the provider was out of office that week, so the family took R27 into the clinic to be seen. Pain assessments scales were completed on the resident's TAR, staff rated a resident's pain using the PAINAD scale and documented the pain number on the TAR each shift. A joint interview was conducted with RN consultant (RN)-D and the director of nursing	F 697		

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F 697	Continued From page 58 (DON) on 1/28/25, at 4:47 p.m. The nurses were really good to offer the PRN pain medication and repositioning as far as interventions and RN-B was working with R27's provider for different options as well. The DON became aware R27 had run out of her PRN oxycodone on 11/28/24, when she came into work the next day and had asked staff to pull pain medications from the facility's emergency kit but was told R27 could not tolerate the doses in the kit. Staff actively worked on trying to get R27's pain medication refilled as quickly as they could. When interviewed on 1/29/25, at 8:00 a.m. the DON stated when a resident needed refill of medication after hours or holidays, the process was for staff to contact the on-call doctor as well as utilize the facility's emergency medications kit (E-kit). R27 could not utilize the medications in the facility's E-Kit because she was already receiving the maximum allowed dose of Tylenol and all the pain medications in the E-kit contained Tylenol, as well as allergies. The facility should never run out of anything, as they were a nursing home. The DON did not know why the on-call doctor was not utilized. The DON would have expected resident's pain to be managed and all resources to be utilized to ensure resident's pain was under control at all times. When interviewed on 1/29/25, at 9:53 a.m. RN-B stated she called the pharmacy to have R27's pain medication refilled and was told the pharmacy had to wait for authorization from the provider. RN-B called the physician's office a couple times regarding the need for refill. RN-B stated she supposed the facility could have contacted the medical director for the refill, but she had not thought of that at the time. R27 was	F 697		

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F 697	Continued From page 59 not always hollering out in pain, and they had put nonpharmacological interventions in place such as lying R27 down in bed and utilizing her Tylenol and Voltaren cream. RN-B had not thought of holding the Tylenol to give R27 the oxycodone with Tylenol from the facility's E-kit. During telephone interview on 1/30/25, at 12:48 p.m. TMA-B stated staff usually gauged when R27 was having pain when R27 started hollering out and say "OW". The facility had re-ordered R27's oxycodone but were waiting for the provider to sign off on the refill, so there was a time when there was no oxycodone available to give R27. R27 did seem to be having more pain during the time the medication was not available, as she was hollering out "OW" or would do a thing where she would just yell out "ahhh, ahh". TMA-B was upset because the only thing she could give R27 on 11/29/24 was Tylenol because there was no oxycodone available. It had happened a couple of times when staff had to wait for R27's oxycodone to come in, it would not arrive from pharmacy until 5:00 p.m. and so at times would have to wait from the beginning of her shift at 2:00 p.m. until the medication arrived at 5:00 p.m., and then was told to give it to R27 immediately when it came in and so she had done so. The facility's policy Pain Management and Assessment dated 5/15, identified if pain relief/reduction was not achieved, staff were to report to RN as soon as possible. The RN would complete a pain assessment when next available and then report to the resident's attending physician any problems with pain control. Assessments would include at minimum: diagnosis, medical status, recognizing when a	F 697		

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F 697	Continued From page 60 resident was experiencing pain, identification of times pain could be anticipated, identifying the cause of pain, and evaluation of existing pain. R29: R29's quarterly MDS dated 10/31/24, identified R29 had intact cognition. R29 received a scheduled and PRN pain medication for frequent pain that occasionally interfered with day-to-day activities. R29's pain was rated 6 on a 0 to 10 scale. Diagnoses included fibromyalgia, chronic pain syndrome, age related osteoporosis, moderate stage rheumatoid arthritis of multiple sites, and intervertebral disc degeneration, lumbar region with back pain. R29's care plan dated 11/6/24, identified R29 was at increased risk for pain with a goal R29 would verbalize adequate pain relief. Interventions included to administer pain medications as ordered, encourage adequate rest periods, observe for pain at least every shift and use of non-pharmacological pain interventions including rest, distraction, ice/warm pack, elevation, and reposition. R29's Physician Order Summary Report dated 12/27/24, identified staff were to monitor and document pain level every shift and included and order for staff to apply Lidocaine external patch 5% to R29's back every morning. When interviewed on 1/29/25, at 10:44 a.m. R29 stated she hurt so badly during the night, she needed help to get to the bathroom. Her pain was all over, and thought it was related to her arthritis. Staff had given her a pain pill at bedtime and Tylenol when she awoke. Sometimes she had to	F 697		

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F 697	Continued From page 61 ask for her Lidocaine patch to be applied. Most of the time the nurses came in when the aides were helping her to dress for breakfast and put it on first thing. A couple of days ago, she had not gotten her pain patch at the usual time. She wheeled out in the hall to visit her spouse around 10:00 a.m. and noticed RN-E in the hall visiting with another staff. R29 told RN-E she would like her pain patch and RN-E told her it was not due until 11:00 a.m. and she would have to wait as it was not time yet. So R29 did not get the patch applied until later and she usually had it when she washed up for the day. RN-E said it did not come up on the medication cart until 11:00 a.m., it was R29's patch and if it was needed, it was needed because she had pain. R29 was not sure exactly which day the late administration of the pain patch had occurred. During subsequent interview on 1/30/25, at 8:54 a.m. R29 stated when going down to visit her spouse in his room around 10:00 a.m. and saw RN-E in the hall, she asked RN-E for her pain patch and was told it did not come up on the computer until 11:00 a.m. so she would have to wait. No one had ever told R29 that before and she had always gotten the pain patch applied right away in the morning when she was getting dressed. The pain patch was for her fibromyalgia. It was her pain patch, and it was the only thing that helped her pain, other than the Tylenol. After RN-E told her she would have to wait, R29 just sat down by her spouse and talked with him and did not say anything more. R29 could not remember if her pain had worsened that day due to receiving the pain patch later than usual as she was in pain all the time. R29 stated that patch was everything, as it helped with everything. When RN-E finally came to her room and applied	F 697		

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F 697	Continued From page 62 the patch, later in the morning, all RN-E did say was here is your patch and applied it to her lower back. R29's Treatment Administration Record (TAR) for January 2025, identified an order for Lidocaine External Patch 5%. Apply to back topically in the morning for chronic pain syndrome. RN-E had signed off administration of R29's Lidocaine patch on 1/4/25, at 10:42 a.m., and on 1/27/25, at 10:43 a.m. During interview on 1/30/25, at 10:29 a.m. TMA-A stated the nurses applied R29's Lidocaine patch in the mornings. TMA-A knew they usually did it around breakfast when R29 was getting ready for the day. The aides would walkie for someone to come down and apply it when they were in there assisting her to get dressed. The Lidocaine patch was ordered every am, so it could be applied anytime R29 asked for it in the morning. When interviewed on 1/30/25, at 2:55 p.m. the DON stated she received a complaint regarding a staff member not responding to a resident's request for pain medication. The complaint identified the pain patch was administered late and caused increase pain to the resident. The facility was in the process of investigating the incident. The DON had conducted a number of interviews and felt the way the nurse interacted with residents may be perceived a little blunt or off-putting at times. The DON had discussed R29's preferences for the time patch and planned to adjust the medication administration time to be more specific. RN-E had been sent home until the investigation was completed. The plan was to have RN-E return to work after receiving education.	F 697		

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F 697	Continued From page 63 The facility policy Medication Administration Times dated 5/2017, identified "AM" medications were to be given between 6:00 a.m. and 10:00 a.m. The facility policy Pain Management and Assessment date 5/2015, identified it was the facility's policy residents remain comfortable and as free from pain as possible. Residents would be monitored for pain on an ongoing basis per regularly scheduled pain assessments, daily observation, administration of analgesic as ordered and follow-up monitoring of medication effectiveness.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755		2/28/25

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F 755	Continued From page 64 aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a medication allergy was clarified prior to administering medication and failed to ensure as needed (PRN) medication was administered under the recommended daily dose for 1 of 1 resident (R27) reviewed for pain. Findings include: R27's significant change Minimum Data Set (MDS) dated 12/12/24, identified R27 had severely impaired cognition. R27 received both scheduled and as needed pain medications. R27 had daily non verbal sounds and facial expressions of pain. R27's Physician Order Summary report dated 1/29/25, identified R27 was ordered acetaminophen 1000 milligrams (mg) three times a day with start date of 1/25/24, as well as acetaminophen 650 mg every four hours as needed with start date 10/31/21. Oxycodone 5 mg every 12 hours as needed was also ordered for severe pain with start date 2/9/24. R27's November Medication Administration	F 755	Failure to assess for allergies and administer medications under the correct PRN parameters places resident at risk for adverse reactions. Between the dates of 2/17/25-2/21/25 an audit of all medication orders was conducted by the consulting pharmacist to ensure current medication orders did not conflict with listed allergies. Additionally, an audit of PRN Tylenol orders to ensure “Max Dose” parameters were included in each order. This resulted in 31 residents Tylenol orders being updated to include “Max Dose” in additional instructions. All orders were updated on 2/21/25. R27 no longer resides at the facility. The facility policy for medication administration was reviewed on 1/21/25. The policy was updated to include explicit instructions for assessing for allergies upon order entry. Additionally, the standing order template for Tylenol was updated in the EMR system to automatically state “Max Dose” for PRN Tylenol. Education to all licensed nurses and TMA’s will be conducted on	

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F 755	Continued From page 65 Record (MAR) 2024, identified acetaminophen 1000 mg was administered three time on 11/29/24, along with administering 650mg of Tylenol for break through pain. The PRN oxycodone had been administered on 11/28/24, at 2:58 a.m. and was next administered 11/29/24, at 7:53 p.m. R27's MAR for September 2024 through December 2024 identified allergies on each MAR and included an allergy to oxycodone. The MAR's identified the following: - September 2024, PRN oxycodone was administered to R27 five times during the month of September, despite oxycodone was listed as an allergy in R27's medical record. - October 2024, PRN oxycodone was administered to R27 20 times during the month of September, despite oxycodone was listed as an allergy in R27's medical record. - November 2024, R27 PRN oxycodone was administered to R27 20 times during the month of November, despite oxycodone was listed as an allergy in R27's medical record. - December 2024, PRN oxycodone was administered 45 times during the month of December, despite oxycodone was listed as an allergy in R27's medical record. R27's Consultant Pharmacy Monthly Reviews were reviewed from January 2024 through December 2024 and identified the consultant pharmacist reviewed R27's medical record every month; however, failed to identify there was a discrepancy regarding the oxycodone order dated	F 755	02/24/25-02/28/25 and include instruction on entering orders, orders flagging for allergy discrepancies, actions to take if allergies are noted. Additionally, education will be provided on Tylenol, max dosing recommendations, and potential effects of exceeding that dose. Beginning in March 2025 the consultant pharmacist will specifically review medication orders for conflicts with allergies and max dosing discrepancies. Noted concern will be place on the pharmacy regimen review forms and provided to the DON for follow up. This will continue to be a specific focus on an ongoing basis. Audits of newly entered orders will be completed by the DON or designee weekly beginning on 3/01/25 with a focus on identifying orders entered despite allergy listing and Tylenol orders missing Max dose instructions. Audits will continue weekly for 4 weeks.	

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F 755	Continued From page 66 2/9/2024 and the listed allergy. R27's medical record lacked documentation the potential drug interaction had been identified and brought to the providers or nurses' attention to be addressed. R27's medical record lacked any evidence R27 experienced and allergic reaction from receiving the oxycodone.' During subsequent interview on 1/29/25, at 8:00 a.m. the director of nursing (DON) stated she noticed R27 was administered her scheduled 3000 mg and then had also received PRN Tylenol 650 mg two times on 11/29/24. The DON stated the acceptable dose for the elderly would be the 3000 mg of Tylenol in a day and the Tylenol R27 had received on 11/29/24, would have exceeded that threshold. During telephone interview on 1/29/25, at 11:00 a.m. consultant pharmacist (CP)-H stated she had not completed R27's monthly medication reviews, as they had been completed by a recent retired pharmacist. CP-H would review the record and answer what questions she was able. CP-H stated it was common practice to review a residents allergy list when reviewing their medications monthly. If a medication had been given that was listed as an allergy, the pharmacist would typically look back in the notes to see if any adverse reaction had occurred. If no reaction occurred would wonder they would question if was a true allergy was or not. They would talk with the nurses and possibly make a recommendation to remove the medication from the allergy list or consider a different pain medication. The medication would not always be	F 755		

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F 755	Continued From page 67 removed from the allergy list, as would want to keep an eye on the administration of the medication, because of a possible adverse reaction to the medication in the past. CP-H reviewed R27's record and could tell through the filling pharmacy's records that R27 did not have a true allergy but rather some adverse reactions and it was ok to fill the medication. CP-H was unable to identify if the previous pharmacist had identified this as there was no notes identifying the potential allergy was reviewed. Further, R27 was receiving the medication without any documented problems, and it would just be alert to keep in mind R27 had had a problem with oxycodone in the past and not a true allergy. During telephone interview on 1/29/25, at 2:49 p.m. CP-H stated she was unable to find documentation the reviewing CP had identified the discrepancy of the ordered medication with R27's allergy list. When interviewed on 1/29/25, at 3:10 p.m. the DON stated she reviewed R27's clinic medical record and was able to find R27's provider had over-ridden the allergy alert when he first ordered the oxycodone, so the provider was aware of the listed allergy. The information was just found when she searched R27's clinic record now and there was no evidence the allergy had been questioned by the facility staff or discussed with the provider when it was ordered. The DON would have expected the consultant pharmacist to have identified the irregularity and to have completed an irregularity report for the provider to review and clarify. During telephone interview on 1/30/25, at 12:48 p.m. trained medication assistant (TMA)-B stated	F 755		

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F 755	Continued From page 68 they administered the PRN Tylenol on 11/29/24. TMA-B was not aware R27 was over the maximum limit of 4000 mg. Normally TMA-B usually just gave R27 her scheduled Tylenol but had been told by the nurse on 11/29/24 to give R27 her PRN Tylenol as well because she was having increased pain and her PRN oxycodone was awaiting a provider refill prescription. The Drugs.Com manufacturers guidance dated 6/10/24, identified acetaminophen can cause acute liver failure, sometimes resulting in liver transplantation and death, can occur. Liver injury usually is associated with doses that exceed the maximum recommended daily dosage and often involves use of more than one acetaminophen-containing preparation. In adults the current limit is 4 g daily (4000mg). Some experts recommend a maximum dosage of 3 g (3000mg) daily when used for long-term therapy (e.g., =2 weeks). FDA is evaluating whether data exist to support establishing a lower (i.e., <4 g daily) maximum daily dosage for certain patients (e.g., those who chronically ingest alcohol). Some manufacturers (e.g., McNeil, Tylenol) voluntarily revised their labeling and currently recommend a maximum dosage of 3 g (3000mg) daily.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		2/28/25

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F 756	Continued From page 69 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist failed to identify and report irregularities related to resident allergies for a prescribed medication for 1 of 1 resident (R27) reviewed for pain. Findings include:	F 756	Failure to identify allergies during routine drug regimen reviews places all residents at risk for poor outcomes and drug interactions. R27 no longer resides at the facility. Between the dates of 2/17/25-2/21/25 an audit of all medication orders was conducted by the consulting pharmacist to	

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F 756	Continued From page 70 R27's significant change Minimum Data Set (MDS) dated 12/12/24, identified R27 had severely impaired cognition. R27 received both scheduled and as needed pain medications. R27 had daily nonverbal sounds and facial expressions of pain. R27's Physician Order Summary report dated 1/29/25, identified an order for oxycodone 5 mg every 12 hours as needed was also ordered for severe pain with start date 2/9/24. R27's Medication Administration Record (MAR) for September 2024 through December 2024 identified allergies on each MAR and included an allergy to oxycodone. The MAR's identified the following: - September 2024, PRN oxycodone was administered to R27 five times during the month of September, despite oxycodone was listed as an allergy in R27's medical record. - October 2024, PRN oxycodone was administered to R27 20 times during the month of September, despite oxycodone was listed as an allergy in R27's medical record. - November 2024, R27 PRN oxycodone was administered to R27 20 times during the month of November, despite oxycodone was listed as an allergy in R27's medical record. - December 2024, PRN oxycodone was administered 45 times during the month of December, despite oxycodone was listed as an allergy in R27's medical record. R27's Consultant Pharmacy Monthly Reviews	F 756	ensure current medication orders did not conflict with listed allergies. The policy for drug regimen reviews was reviewed and is current with no changes being made. The consultant pharmacist who conducted reviews in 2024 is no longer working with the company. The current consultant pharmacist has been educated on facility expectations for attention being given to allergies on 2/19/25 via phone call with Corporate RN. Beginning in February 2025 the consultant pharmacist will specifically review medication orders for conflicts with allergies and max dosing discrepancies. Noted concern will be placed on the pharmacy regimen review forms and provided to the DON for follow up. This will continue to be a specific focus on an ongoing basis.	

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F 756	Continued From page 71 were reviewed from January 2024 through December 2024 and identified the consultant pharmacist reviewed R27's medical record every month; however, failed to identify there was a discrepancy regarding the oxycodone order dated 2/9/2024 and the listed allergy. R27's medical record lacked documentation the potential drug interaction had been identified and brought to the providers or nurses' attention to be addressed. R27's medical record lacked any evidence R27 experienced and allergic reaction from receiving the oxycodone. During telephone interview on 1/29/25, at 11:00 a.m. consultant pharmacist (CP)-H stated she had not completed R27's monthly medication reviews, as they had been completed by a recent retired pharmacist. CP-H would review the record and answer what questions she was able. CP-H stated it was common practice to review a residents allergy list when reviewing their medications monthly. If a medication had been given that was listed as an allergy, the pharmacist would typically look back in the notes to see if any adverse reaction had occurred. If no reaction occurred would wonder they would question if was a true allergy or not. They would talk with the nurses and possibly make a recommendation to remove the medication from the allergy list or consider a different pain medication. The medication would not always be removed from the allergy list, as would want to keep an eye on the administration of the medication, because of a possible adverse reaction to the medication in the past. CP-H reviewed R27's record and could tell through the filling pharmacy's records that	F 756		

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F 756	Continued From page 72 R27 did not have a true allergy but rather some adverse reactions and it was ok to fill the medication. CP-H was unable to identify if the previous pharmacist had identified this as there was no notes identifying the potential allergy was reviewed. Further, R27 was receiving the medication without any documented problems, and it would just be alert to keep in mind R27 had had a problem with oxycodone in the past and not a true allergy. During telephone interview on 1/29/25, at 2:49 p.m. CP-H stated she was unable to find documentation the reviewing CP had identified the discrepancy of the ordered medication with R27's allergy list. When interviewed on 1/29/25, at 3:10 p.m. the DON stated she reviewed R27's clinic medical record and was able to find R27's provider had over-ridden the allergy alert when he first ordered the oxycodone, so the provider was aware of the listed allergy. The information was just found when she searched R27's clinic record now and there was no evidence the allergy had been questioned by the facility staff or discussed with the provider when it was ordered. The DON would have expected the consultant pharmacist to have identified the irregularity and to have completed an irregularity report for the provider to review and clarify. The facility's policy Medication Regimen Review (monthly report) dated 8/2017, identified the consultant pharmacist would complete a comprehensive medication regimen review (MMR) at least monthly. The MMR included evaluating the resident's response to medication therapy to determine the resident maintained the	F 756		

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F 756	Continued From page 73 highest practicable level of function and to prevent or minimize adverse consequences related to medication therapy. Findings and recommendations would be reported to the DON for follow up with the attending physician.	F 756		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse,	F 851		2/28/25

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F 851	Continued From page 74 certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure licensed nursing staff hours were submitted accurately on the payroll-based journal. This had the potential to affect all 32 residents residing in the facility. Findings include: The PBJ (payroll-based journal) Staffing Report CASPER Report 1705D FY [fiscal year] Quarter 4	F 851	Failure to complete accurate PBJ data submission has the potential to negatively impact quality measures and data used for direct resident care staffing decisions and desirable resident outcomes. PBJ data is not able to be edited therefore previously submitted data will remain as is. On 2/15/25 PBJ data for October 1, 2024-December 31, 2024 was submitted	

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F 851	Continued From page 75 2024 (July 1 - September 30) identified the facility had excessively low weekend staffing and failed to have licensed nursing coverage 24 hours/day on the following days: 7/23/24, 7/24/24, 7/25/24, 7/26/24, 7/27/24, 7/28/24, 7/29/24, 7/30/24, 7/31/24, 8/20/24, 8/21/24, 8/22/24, 8/23/24, 8/24/24, 8/25/24, 8/26/24, 8/27/24, 8/28/24, 8/29/24, 8/30/24, 8/31/24, 9/16/24, 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/28/24, 9/29/24, and 9/30/24. The facility payroll and working scheduled were reviewed for 7/1/24 through 9/30/24 and there was a licensed nursing staff 24 hours/day consecutively on all 36 days identified on the PBJ report. During an interview on 1/29/25 at 8:49 a.m., registered nurse (RN)-B stated during quarter 4 2024, she was a salaried employee, and she did not use the timeclock even though she worked charge nurse shifts during that time. During an interview on 1/29/25 at 9:34 a.m., registered nurse (RN)-D, who was the corporate nurse, stated the administrator was responsible for submitting the PBJ for the facility, but the administrator was unavailable due to a family emergency. RN-D stated she was aware the administrator was having difficulty submitting the PBJ data and had to "hand enter" the information. The facility always had licensed staff in the building 24 hours/day, however, salaried employees were not using the timeclock system. A policy/procedure regarding PBJ data submission was requested but not provided.	F 851	as required by regulation. Prior to final submission all days were audited for staff hours and accuracy including 24-hour licensed nursing staff and RN hours. The facility is additionally actively working with the payroll software system to correct errors in reports previously used to submit data to CMS. All submissions through 2/2026 will be audited by the facility administrator and corporate RN prior to quarterly submission deadlines to ensure comprehensive and accurate data submission. This will be completed quarterly, the week prior to PBJ submission deadlines. The data entered into the system will be compared to time cards and schedules to ensure accurate reflection of hours worked including 8-hour/day RN coverage and 24-hour/day licensed nursing staff.	

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F 867	Continued From page 76	F 867		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the	F 867		2/28/25

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F 867	Continued From page 77 facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and	F 867		

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F 867	Continued From page 78 implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop, monitor, and evaluate their identified performance measures. This had	F 867	Failure to develop a QAPI program that is capable of data review, goal setting and performance improvement has the	

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F 867	Continued From page 79 the potential to affect all 46 residents residing in the facility. Findings include: The Facility Assessment dated 1/2025, identified the facility was a Medicare and Medicaid certified skilled nursing facility. The facility was licensed for 35 beds with an average daily census in the past year of around 34. The facility provided skilled nursing, unskilled nursing, short- and long-term care. Additional services offered are care for those with dementia or other cognitive deficits, end-of-life care, behavioral health, spiritual care, nutritional services, housekeeping, laundry, wound care, ostomy care, dialysis coordination, care of chronic and acute illnesses, oxygen therapy, physical/occupational/speech therapies, restorative and functional maintenance programs, care coordination with physicians, clinics and specialists. Facility Assessment and QAPI Information from the Facility Assessment was used to inform the Quality Assurance Performance Improvement (QAPI) process as indicated in the QAPI Plan. Improvement projects would focus on high-risk or problem-prone areas that the facility had identified through data collection of various sources as indicated in the facility policy and procedure for Quality Assurance and Performance Improvement. The description of care, services, and resources available at the facility provided both areas for monitoring processes and outcomes as well as information for investigation of root causes of adverse events and gaps in performance. The facility held QAPI meetings on a scheduled quarterly basis and more often, if indicated. The QAPI team consisted of representatives from each	F 867	potential to impact all residents living within the facility. The facility policy Quality Assurance and Performance Improvement (QAPI) program was reviewed on 2/20/25 with no changes being made. A formal agenda was formatted based off current policy to serve as an active working document during QAPI meetings to ensure the developed performance measures are monitored and evaluated and attainable and measurable goals are developed using facility data. At the 3/5/2025 QAPI meeting, an in-depth discussion will be held to determine quality improvement project focus with data review and measurable goal development. Audits of QAPI data, goals and progress will be conducted by the corporate RN following each meeting for the next 3 quarters to ensure compliance and expected attendance. Results of audits will be reviewed with the QAPI team for determination of compliance and ongoing auditing needs.	

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F 867	Continued From page 80 department along with open invitations to residents and direct care staff. The QAPI process was conducted according to industry standards. The Plan, Do, Study, Act process was used to review and implement and review effectiveness of improvement projects. The Quality and Safety Meeting dated 4/17/24, identified the following: Performance Improvement Projects: Fall Reduction: Have seen on-going root cause analysis, intervention review and education. - Walk to dine program - have increased walking for those who tolerate. Currently have ten, last quarter were eight participating. Four walking to all three meals, four walking to at least two meals, and two walking once daily - Restorative program - continuing to work towards getting up and going. Infection Control: focus on infection control rates, enhanced barrier precautions and audits. - Audits and training for EBP - Ensuring EBP rooms are fully stocked and staff knowledge - Training in new IP nurse The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality and Safety Meeting dated 7/18/24, identified the following: Performance Improvement Projects: Fall Reduction: Have seen on-going root cause analysis, intervention review and education. - Walk to dine program have increased walking for those who tolerate. Currently we have 8, last quarter was 1 participating. 4 walking to all three meals, 2 walking to at least two meals, and 2 walking once daily.	F 867		

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F 867	Continued From page 81 - Restorative program - continuing to work towards getting up and going. A full-time therapy aide hired, starting July 22nd, will support restorative programs. Infection Control: focus on infection control rates, enhanced barrier precautions and audits. - Audits and training for EBP have been completed. - Continuing to ensure EBP rooms are fully stocked and staff knowledge. - Ongoing training in new IP nurse. The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The Quality and Safety Meeting dated 10/16/24, identified the following: Performance Improvement Projects Fall Reduction: Have seen on-going root cause analysis, intervention review and education. - Walk to dine program -have increased walking for those who tolerate. Currently we have 8 participating. 4 walking to all three meals, 2 walking to at least two meals, and 2 walking once daily. - Restorative program -continuing to work towards getting up and going. Infection Control: Focus on infection control rates, enhanced barrier precautions and audits. - Audits and training for EBP have been completed. - Continuing to ensure EBP rooms are fully stocked and staff knowledge. - Ongoing training in new IP nurse. The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. The facility QAPI Meeting Minutes dated 1/15/25,	F 867		

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F 867	Continued From page 82 identified the following: Performance Improvement Projects - Fall Reduction: Root cause analysis, interventions, and education ongoing. - Walk to dine program expanded. - Restoration program implemented. - Infection Control: Focus on rates, precautions, and audits. - QIPP Project - Nutrition: Snack survey completed, monthly dietician meetings. - Dining room: Audits conducted; access improved. - Weight loss/nutrition: Reports reviewed; bi-monthly weights implemented. The data failed to identify the facility developed and implemented action plans with measurable goals and/or identify actions taken. During an interview on 1/30/25 at 2:13 p.m., with the director of nursing (DON) and registered nurse (RN)-D, RN-D stated the administrator was unavailable for interview. RN-D stated the minutes did identify actions aimed at performance improvement, however, did not identify a measurement of success, and track performance to ensure that improvements were realized and sustained. The facility policy Quality Assurance and Performance Improvement (QAPI) Program dated 6/2018, identified the objective of this requirement is the completion and implementation of the QAPI plan to identify the high risk, problem prone and high volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristic and needs of the residents. 1. The facility will develop, implement and maintain a QAPI program that is effective, data	F 867		

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F 867	Continued From page 83 driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. 2. The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as: 3. Tracking and measure performance; 4. Establishing goals and thresholds for performance measurement; 5. Identifying and prioritizing quality deficiencies; 6. Systematically analyzing underlying causes of systemic quality deficiencies; 7. Developing and implementing corrective action or performance improvement activities; and 8. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. 9. The facility maintains documentation and can demonstrate evidence that the program meets CMS requirements 10. The facility presents evidence in the form of documentation to substantiate the ongoing implementation and QAPI program compliance with regulations to the State Survey Agency, Federal Surveyor or CMS if requested. 11. The Quality Assessment and Assurance Committee consists at a minimum of: a. The Director of Nursing; b. The Medical Director or his/her designee; c.. At least three other members of the facility's staff, at least one of who must be the Administrator, owner, a board member or other individual in a leadership role; and d. The infection Preventionist - effective November 28, 2019. 6. The QAPI plan describes the methods to validate and update staff competencies at the time of hire and periodically. 7. The QAPI plan ensures that residents provide	F 867		

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F 867	Continued From page 84 input to prioritize the areas to monitor and measure that reflect the resident's preferences, ethnic, cultural, and religious considerations. 8. Contract staff will contribute data and information and collaborate within the QAPI program. 9. QAA meetings will be held at least quarterly and with enough frequency to conduct required QAPI/QAA activities. 10. All facility staff, contracted staff, and volunteers will be educated about the QAPI plan and their role in development and implementation of interventions. 11. A plan will be in place to ensure that agency staff are educated on the facility QAPI plan. 12. The QAPI plan will be reviewed annually and with any significant change at the facility.	F 867		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 868		2/28/25

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F 868	Continued From page 85 program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assurance (QA) committee held meetings with the required members on a, at minimum, quarterly basis. This had potential to affect all 32 residents residing in the facility at the time of the survey. Findings include: The Quality and Safety Meeting minutes dated 7/18/24, failed to identify the medical director was in attendance or had been provided the information for review and provide opportunity for feedback. The Quality and Safety Meeting dated 10/16/24, identified the director or nursing, consultant pharmacist and medical director were not in attendance or had been provided the information for review provide opportunity for feedback.	F 868	Failure to have all QAA members present at QAPI meetings has the potential to affect all residents and the quality of care provided within the facility. QAPI meetings will continue to be held on at least a quarterly basis. A special meeting with all QAA members being present will be held on 3/5/25 to review expectations of attendance. The facility policy Quality Assurance and Performance Improvement (QAPI) program was reviewed with no changes made. An agenda was formatted based off current policy to serve as an active working document during QAPI meetings to ensure the developed performance measures are monitored and evaluated. During special session of QAPI meeting on 3/5/25, data will be reviewed with goals and action plans being developed.	

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	245592	A. BUILDING _____ B. WING _____	C 01/30/2025

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F 868	Continued From page 86 During an interview on 1/30/25 at 2:13 p.m., with the director of nursing (DON) and registered nurse (RN)-D, RN-D stated the administrator was unavailable for interview. RN-D stated the information in the meeting minutes identified the required members did not attend; however, believed they were available by phone at any time needed. The facility policy Quality Assurance and Performance Improvement (QAPI) Program dated 6/2018, identified the objective of this requirement is the completion and implementation of the QAPI plan to identify the high risk, problem prone and high-volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristic and needs of the residents. 1. The facility will develop, implement and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. 2. The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as: 3. Tracking and measure performance. 4. Establishing goals and thresholds for performance measurement. 5. Identifying and prioritizing quality deficiencies. 6. Systematically analyzing underlying causes of systemic quality deficiencies. 7. Developing and implementing corrective action or performance improvement activities; and 8. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. 9. The facility maintains documentation and can	F 868	Audits of QAPI attendance and documentation will be conducted by the corporate RN following each meeting for the next 3 quarters to ensure compliance and expected attendance. Results of audits will be reviewed with the QAPI team for determination of compliance and ongoing auditing needs.	

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F 868	Continued From page 87 demonstrate evidence that the program meets CMS requirements 10 . The facility presents evidence in the form of documentation to substantiate the ongoing implementation and QAPI program compliance with regulations to the State Survey Agency, Federal Surveyor or CMS if requested. 11. The Quality Assessment and Assurance Committee consists at a minimum of: a. The Director of Nursing. b. The Medical Director or his/her designee.	F 868		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		2/28/25

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F 880	Continued From page 88 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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F 880	Continued From page 89 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 2 of 2 residents (R14, R15) with wound care and failed to ensure personal protective equipment was used during the sorting of soiled laundry. Findings include: EBP: R14 R14's quarterly Minimum Data Set (MDS) dated 1/8/25, identified R14 had a severe cognitive impairment and diagnoses included dementia, anorexia, and chronic kidney disease. R14 was at risk for pressure ulcers but had no current pressure ulcers. R14's care plan revised 1/13/25, failed to identify R14's right great toe wound and/or the need for enhanced barrier precautions (EBP) to prevent infection. During an observation on 1/29/25 at 1:57 p.m., NA-A assisted with personal hygiene and pivot transfer from R14's bed to wheelchair. NA-A did wear gloves but failed to wear a gown during high contact activities. There was no signage, personal protective equipment (PPE) and/or cart in R14's room. During an observation on 1/29/25 at 3:16 p.m., nursing assistant (NA)-B assisted R14 to pivot transfer from R14's wheelchair to bed. NA-B did	F 880	Failure to properly implement proper infection prevention and control procedures has the potential to impact all residents who reside in the facility. R14's wound that requires EBP has since healed. A chart audit conducted by the DON that included review of all current residents with impaired skin integrity completed on 2/21/25 indicated that 2 additional residents required EBP for openings in the skin present for longer than 2 weeks. Additionally, disposable gowns were provided to laundry staff to be worn when sorting soiled laundry on 2/12/25. The current facility policy for EBP includes when EBP is indicated and was not revised. Soiled linen policy has been reviewed by leadership with edits made to include a standardized laundry workflow that includes best practices in infection control and use of disposable gowns. Staff education for expectations of wearing gowns and gloves when EBP is warranted was completed at an all staff meeting held between the dates of 2/24/25 and 2/28/25. Education has also been provided to all staff regarding expectations of gown use during laundry sorting activities. DON or designee will audit high risk contact activities with staff 10 times a week for 2 weeks followed by 5 times a week for 4 weeks. Audit will occur across all shifts. If at such time staff observation results in inadequate EBP practice, DON	

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F 880	Continued From page 90 not don a gown or gloves. There was no signage, personal protective equipment (PPE) and/or cart in R14's room. During an observation on 1/29/25 at 4:22 p.m., registered nurse (RN)-B changed R14's dressing. There was no signage, personal protective equipment (PPE) and/or cart in R14's room. RN-B wore gloves but did not put on a gown. R14 had two open areas at the base of her right great toenail. The measurements for the first area were 0.5 cm x 0.4 cm and the second measured 0.3 cm x 0.1 cm. The areas were dry and scabbed. During an interview on 1/29/25 at 4:40 p.m., RN-B stated R14 should have been placed in enhanced barrier precautions (EBP) on 1/7/25 due to a chronic wound and was not. R15 R15's significant change Minimum Data Set (MDS) dated 11/21/24, identified R15 had a moderate cognitive impairment and diagnoses that included weakness, type 2 diabetes, and chronic kidney disease. R15 was at risk for pressure ulcers and R15 had a burn. R15's care plan revised 12/3/24, identified enhanced barrier precautions for R15 due to R15 was at risk for infection due to right hip wound. Staff were directed to use hand hygiene, gown and glove during care with expected exposure to blood, bodily fluids, skin breakdown, or mucus membranes. During an observation on 1/28/25 at 9:24 a.m., trained medication aide (TMA)-A assisted R15 to transfer from R15's wheelchair to R15's recliner	F 880	or designee will provide real time feedback and education to specific staff member. The IP will audit laundry sorting activities at a rate of 5x/week for 4 weeks, followed by 4x/month for 2 months. Results of all EBP and laundry procedure audits will be reported to the QA committee on an ongoing basis until such time is determined to be in substantial compliance.	

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F 880	Continued From page 91 using a full standing lift. TMA-A did not apply gown or gloves during the transfer. An EBP sign was hanging on the outside of the bathroom door with a plastic 3 tier bin inside R15's bathroom containing disposable gowns and gloves. During an interview on 1/29/25 at 9:13 a.m., TMA-A stated she did not wear a gown or gloves during R15's transfer because that was only if staff were doing cares, like toileting, or dressing changes. During an interview on 1/30/25 at 10:43 a.m., the director of nursing (DON) stated staff were expected to follow the facility's EBP policy to prevent infection. The facility policy Infection Prevention and Control Program revised 1/20/25, identified standard and transmission-based precautions were to be followed to prevent the spread of infections. However, the policy failed to identify EBP and/or when EBP would be used. Laundry During a tour of the laundry department on 1/29/25 at 8:28 a.m., a black fabric apron hung from a hook on the wall in the soiled laundry room. A 6-drawer plastic bin was on the floor underneath the hook, but no other aprons and/or disposable gowns were available. Laundry aide (LA)-A stated the staff wore the same black fabric apron throughout the day to sort soiled laundry because they only had the one because the ties broke on the "other one". Each time soiled items needed to be sorted, the laundry staff would put the apron on and hang it back up on the hook when the sorting was done. The apron would be	F 880		

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F 880	Continued From page 92 washed at the end of the day. LA-A stated there used to be a box of disposable gowns, however, those "disappeared." LA-A stated it was "yucky" to put the apron on because you could see "skin cells and stuff" on the apron as the day went on and LA-A could see why the facility wanted laundry staff to wear an apron to protect their clothing. During an interview on 1/29/25 at 11:13 a.m., RN-D stated laundry staff were expected to wear a long sleeve, impermeable gown while sorting soiled laundry to prevent the contamination of their uniforms as well as preventing the contamination of clean laundry during folding. Staff should always wear a gown and gloves and, if a chance of splashing, a face mask/shield and eye protection. A facility policy regarding infection prevention and control during soiled laundry sorting was requested but not received.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/30/2025. At the time of this survey, Oakland Park Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/22/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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	K 000		

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K 000	Continued From page 2 Installation of Sprinkler Systems. The facility has a fire alarm system with smoke detection at the smoke barriers for door release, in corridors and in common areas that are open to the corridor. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire alarm system. The facility has a capacity of 95 beds and had a census of 80 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222		2/28/25

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K 222	Continued From page 3 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222		

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K 222	Continued From page 4 Based on observation and staff interview, the facility failed to maintain the proper operation of exit door locking device system per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/30/2025, between 9:00am to 1:00pm, it was revealed by observation the emergency exit door that exits from the Paradise Wing did not open when tested. The emergency exit required activation of special knowledge and/or activation of special lock release. This locking arrangement would require documentation of special patient care requirements. An interview with the Director of Maintenance and Regional Director of Nursing verified these deficient findings at the time of discovery.	K 222	The facility failed to maintain proper operation of the exit door locking system per NFPA 101 due to inadequate training, unclear procedures, and a potential faulty mechanism. To address this, the Maintenance Director will immediately conduct a comprehensive inspection of all exit doors and locking mechanisms, documenting compliance with NFPA 101. This includes verifying mechanism type, operational status, fail-safe mechanisms, and supporting systems. Non-compliant systems will be corrected or removed. The Maintenance Director will also train all staff in proper operation of exit door locking systems. Existing policies and procedures will be revised to align with NFPA 101 and clearly define responsibilities. Regular refresher training will be provided. The Maintenance Director will create and maintain detailed documentation for each system. This plan will be completed by Feb 28, 2025. The Maintenance Director will monitor effectiveness for three months via weekly inspections, with results reviewed monthly by the Administrator and safety committee.	
K 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	K 226		2/28/25

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	245592	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/30/2025**

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

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K 226	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell arrangement and markings per NFPA 101 (2012 edition), Life Safety Code, section 19.1.1.4.1.1, 19.1.1.4.1.2, 19.1.1.4.1.3, 19.2.2.2.7, Chapter 7, section 7.2.1.4.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/30/2025, between 9:00am to 1:00pm, it was revealed by observation that the exit door at the end of Sunshine wing did not open 30psi of force and was unable to be continued in operation with a maximum force of 15psi. An interview with the Director of Maintenance and Regional Director of Nursing verified these deficient findings at the time of discovery.	K 226	The facility failed to maintain proper markings per NFPA 101, specifically regarding the excessive force required to open the Sunshine wing exit door. To address this, the Maintenance Director will immediately repair or replace the deficient door and inspect all exit doors for NFPA 101 compliance, correcting any issues. The Maintenance Director will implement a regular inspection/maintenance schedule for all exit doors and keep record. A preventative maintenance program for exit doors will be established. Regular refresher training will be provided. These actions will be completed by Feburary 28, 2025. The Maintenance Director will conduct weekly inspections of all exit doors for three months with results reviewed monthly by the Administrator and safety committee.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321		2/28/25

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K 321	Continued From page 6 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/30/2025, between 9:00am to 1:00pm, it was revealed by observation that there the fire barrier and/or fire wall doors failed to close when tested. An interview with the Director of Maintenance and Regional Director of Nursing verified these deficient findings at the time of discovery.	K 321	The facility failed to maintain smoke barriers per NFPA 101, specifically fire barrier and/or fire wall doors that failed to close properly, due to inadequate training, unclear procedures, and a potential faulty mechanism. To address this, the Maintenance Director will immediately inspect all fire barriers and fire wall doors, ensuring proper closure and addressing any deficiencies, such as damaged hardware or obstructions, through repair or replacement. To prevent recurrence, the Maintenance Director will implement a schedule for regular inspection and maintenance of all fire barrier and fire wall doors, including checks for closure, hardware functionality, and clear access, maintaining detailed inspection logs. These corrective actions will be	

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K 321	Continued From page 7	K 321	completed by Feb 28, 2025. The Maintenance Director will conduct weekly inspections of all fire barriers and fire wall doors for three months, verifying proper closure and functionality, with inspection results reviewed monthly by the Administrator and safety committee.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: 1) Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section	K 353	The facility failed to maintain the sprinkler system per NFPA standards by not performing the required quarterly testing, due to inadequate scheduling/tracking and poor documentation. To address this, the Maintenance Director will immediately schedule and oversee the required testing	2/28/25

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K 353	Continued From page 8 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/30/2025, between 9:00am to 1:00pm, it was revealed by a review of available documentation the facility failed to perform the quarter sprinkler system testing. Last documentation indicated that annual test was completed on 02/28/2023 An interview with the Director of Maintenance and Regional Director of Nursing verified these deficient findings at the time of discovery.	K 353	by a qualified party, to be scheduled by Feb 28, 2025, and update all system documentation. To prevent recurrence, the Maintenance Director will implement a comprehensive preventative maintenance schedule per NFPA 25, establish a clear documentation system. Any existing maintenance contracts will be reviewed for compliance. For three months, the Maintenance Director will conduct monthly reviews of sprinkler system documentation to ensure compliance with findings reported to the Administrator and safety committee.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire	K 761	The facility failed to inspect fire doors annually by NFPA standards, due to	2/28/25

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K 761	Continued From page 9 doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/30/2025, between 9:00am to 1:00pm, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. An interview with the Director of Maintenance and Regional Director of Nursing verified these deficient findings at the time of discovery.	K 761	unfamiliarity with NFPA 80 requirements, lack of a scheduled door inspection program, and inadequate documentation practices. To address this, the Maintenance Director will immediately schedule and oversee the required annual fire door inspections, to be conducted by a qualified individual or company in accordance with NFPA 80, with all findings documented. This inspection will be completed by Feb 28, 2025. To prevent recurrence, the Maintenance Director will implement a fire door inspection program adhering to NFPA 80, including annual inspections and any other necessary maintenance. A clear and organized system for documenting all inspections and maintenance will be established. For three months, the Maintenance Director will conduct monthly reviews of fire door inspection documentation to ensure compliance with findings reported to the Administrator and safety committee.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6,	K 914		2/28/25

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K 914	Continued From page 10 which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/30/2025, between 9:00am to 1:00pm, It was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. An interview with the Director of Maintenance and Regional Director of Nursing verified these deficient findings at the time of discovery.	K 914	The facility failed to conduct electrical testing and maintenance per NFPA 99, specifically lacking documentation of annual receptacle inspections. To address this, the Maintenance Director will complete and oversee the required electrical testing, including receptacle inspections and line isolation monitor (LIM) tests, to be conducted by a qualified individual or Maintenance Director in accordance with NFPA 99. This test will be scheduled by Feb 28, 2025. To prevent recurrence, the Maintenance Director will implement an electrical maintenance and testing program adhering to NFPA 99. A clear and organized system for documenting all testing and maintenance activities will be established. For three months, the Maintenance Director will conduct monthly reviews of electrical testing documentation to ensure compliance, with findings reported to the Administrator and safety committee.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		2/28/25

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K 918	Continued From page 11 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition),	K 918	The facility failed to accurately assess and inspect the emergency generator system by NFPA standards, with overdue	

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K 918	Continued From page 12 Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 01/30/2025, between 9:00am to 1:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing weekly generator inspections were not performed since 05/01/2024. 2) On 01/30/2025, between 9:00am to 1:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing monthly generator inspections were not performed since 05/01/2024. 3) On 01/30/2025, between 9:00am to 1:00pm, it was revealed by a review of available documentation of the emergency generator annual service was last completed on 01/27/2024 An interview with the Director of Maintenance and Regional Director of Nursing verified these deficient findings at the time of discovery.	K 918	weekly/monthly inspections and annual service. A comprehensive generator test will be scheduled with a qualified party by Feb, 28th, 2025. A maintenance program will be implemented by NFPA standards, a clear documentation system established, and documentation procedures. For three months following, the Maintenance Director will conduct monthly reviews of generator system documentation, with findings reported to the Administrator and safety committee.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable	K 920		2/28/25

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K 920	Continued From page 13 patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/30/2025, between 9:00am to 1:00pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the Staff Dinning Room.	K 920	The facility failed to comply with NFPA 99 and NFPA 70 regarding the use of power strips and extension cords, specifically by allowing several electrical appliances to be plugged into power strips, multi-plug adapters, and/or extension cords in the Staff Dining Room. This was immediately corrected during inspection. Any necessary electrical appliances will be connected directly to wall outlets or relocated to appropriate areas. The Maintenance Director will then conduct a facility-wide inspection to identify and correct any similar violations in other areas. Staff will be trained in the proper use of power strips and extension cords, including limitations, safety precautions,	

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K 920	Continued From page 14 An interview with the Director of Maintenance and Regional Director of Nursing verified these deficient findings at the time of discovery.	K 920	and the requirements of NFPA 99 and NFPA 70. To prevent recurrence, the Maintenance Director will implement regular inspections of electrical equipment usage throughout the facility, ensuring compliance with NFPA standards. Clear signage outlining approved and prohibited uses of power strips and extension cords will be posted in staff areas. These corrective actions will be completed by Feb 28, 2025. For three months following, the Maintenance Director will conduct weekly inspections of staff areas, including the dining room, to monitor compliance with power strip and extension cord usage. Findings will be documented and reported monthly to the Administrator and safety committee.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual	K 923		2/28/25

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OAKLAND PARK NURSING HOME	**123 BAKEN STREET** **THIEF RIVER FALLS, MN 56701**

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K 923	Continued From page 15 cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per Health Care Facilities Code NFPA 99 (2012 Edition), sections 11.3.2.3 (1-3), 11.6.5.2 and 11.6.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/30/2025, between 9:00am to 1:00pm, it was revealed by observation that oxygen cylinders are stored in an area with known hazards (electrical boxes and hot water heater without a continues fire wall with 30min rated door. An interview with the Director of Maintenance and Regional Director of Nursing verified these	K 923	The facility failed to store oxygen cylinders safely per NFPA 99, specifically by storing them in an area with known hazards (electrical boxes and a hot water heater) without adequate fire separation. To address this, the existing storage area will be modified to meet these requirements and will include installing a fire-rated partition with a self-closing fire door to create a dedicated storage area within the existing space. All staff involved in handling or storing oxygen cylinders will be trained in NFPA 99 requirements for safe storage practices. To prevent recurrence, the Maintenance Director will implement regular inspections of gas cylinder storage areas to ensure ongoing compliance with NFPA 99. Clear signage	

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 _____	**01/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 16 deficient findings at the time of discovery.	K 923	outlining safety precautions and storage requirements will be posted in the storage area. These corrective actions will be completed by Feb 28, 2025. For three months following, the Maintenance Director will conduct weekly inspections of the oxygen cylinder storage area to monitor compliance with NFPA 99. Findings will be documented and reported monthly to the Administrator and safety committee.	