



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2025

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

RE: CCN: 245592

Cycle Start Date: July 17, 2025

Dear Administrator:

On July 17, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On July 2, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 listed below to the CMS location.

- **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.

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 17, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, OAKLAND PARK NURSING HOME is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation

Programs for two years effective July 17, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

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

Sincerely,

Kamala Fiske-Downing

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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245592	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025
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NAME OF PROVIDER OR SUPPLIER OAKLAND PARK NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 123 BAKEN STREET , THIEF RIVER FALLS, Minnesota, 56701
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F0000	<p>INITIAL COMMENTS</p> <p>On 7/15/25 through 7/17/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed H55928969C (MN00114396) with a deficiency issued at F689 PAST NON-COMPLIANCE.</p> <p>Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.</p>	F0000		
F0689 SS = SQC-J	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based observation, interview and document review the facility failed to ensure staff transporting residents in a facility vehicle were trained on safe transport practices and had appropriate driver's license clearance for 3 of 3 (R1, R2, R3) residents reviewed for accidents. This resulted in an immediate jeopardy for R1 when he fell from his wheelchair to the floor of the van during transport after being improperly</p>	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0689 SS = SQC-J	<p>Continued from page 1 secured.</p> <p>Findings include:</p> <p>The immediate jeopardy (IJ) began on 7/2/25, at approximately 4:00 p.m., when nursing assistant (NA)-A was directed to transport R1 to the hospital, loaded him in the front passenger's seat of the van, securing only two out of the four required four-point tie downs, and no seat/lap belt. R1's wheelchair fell backwards onto the floor of the van during transport resulting in a skin tear on top of the left hand. Additionally, NA-A driver's license had not been cleared by the facility's insurance prior to this incident. The IJ was identified on 7/17/25, the administrator was notified of the IJ on 7/17/25, at 4:15 p.m. The IJ was removed on 7/2/25, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance.</p> <p>R1's admission Minimal Data Set dated 6/23/25, identified moderate cognitive impairment.</p> <p>R1's Morse Fall Scale (a tool used to assess fall risk) completed on 6/30/25 at 1:49 p.m. identified a history of falls, used a wheelchair for mobility, and impaired and weak gait. His fall risk score was 40 (low risk 0 to 24, moderate risk 25 to 44, high risk 45 or higher), and placed him at moderate risk for falls.</p> <p>R1's care plan dated 6/27/25, identified he had poor decision-making abilities and impaired safety awareness.</p> <p>R1's progress notes from 7/2/25 through 7/4/25, identified:</p> <p>-On 7/2/25 at 4:47 p.m., writer was alerted by daughter-in-law the new onset of confusion and worsening slurred speech. Upon assessment, resident was pale and noted to be having hard retention of fluid in abdomen, bilateral upper and lower extremities. He talked nonsense, had delayed responses to questions, confusion, and incomprehensible speech. He was sent to emergency department (ED) via facility van as he was unable to get into daughter-in-law's vehicle. He left facility at 4:16 p.m. with necessary paperwork.</p> <p>-On 7/2/25 at 6:30 p.m. local hospital called and</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 2 indicated he was being admitted for pneumonia.</p> <p>-On 7/3/25 at 12:01 p.m., received nurse report from local hospital ambulance would bring him back to facility, scans clear, laceration to left hand covered with mepilex, left elbow skin covered with steri strip. Family discussed comfort care, oxygen 3 liters (L).</p> <p>-On 7/3/25 at 1:56 p.m., he returned to facility via ambulance at 12:50 p.m. . . minimally responsive.</p> <p>-On 7/3/25 at 3:25 p.m., fall assessment- In facility van on 7/2/25, via in route to ED for evaluation after change in condition. R1 was assisted to van with brake locks and tie downs being applied to front and rear. During transport he tipped backwards in wheelchair and sustained a skin tear to left hand. Staff present helped him back to seated position and continued to ED for evaluation. Unknown if he hit head, sustained back of left hand skin tear. Baseline mental status: oriented to person, place and time. Displayed poor safety awareness and long, short term memory loss, and recent decline in activities of daily living (ADL) abilities.</p> <p>-On 7/3/25 at 3:44 p.m. he returned on comfort cares; hospitalist prescribed comfort measures.</p> <p>Facility incident report identified on 7/2/25 at 4:00 p.m., R1 experienced a change in condition and was determined he should be seen in the emergency department (ED) for evaluation. R1 was assisted to load in his wheelchair into the facility van with an oxygen tank by staff who secured straps front and rear of wheelchair. When accelerating after stopping at a stop sign, R1's wheelchair came loose from the tie down and tipped backwards. He was assisted back to an upright position and driver proceeded to ED. Per staff report there was a red spot on his head, no bleeding and a skin tear to left hand. CT scan showed no other injuries. He was admitted to the hospital for treatment of pneumonia.</p> <p>ED triage notes dated 7/2/25 at 4:10 p.m., identified R1 arrived to ED via wheelchair with family with complaints of slurred speech, confusion and a fall on the way to ED. Family was told by nursing home (NH) staff that he was having mini strokes due to his noted slurred speech and confusion that had started today but had not given a timeframe of events to family or ED staff. On the way to the hospital, NH staff told family they did not have a front strap for his wheelchair and</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 3 when staff hit the brakes, he proceeded to fall backwards while in the wheelchair and hit his head. No blood thinners on chart, no injury noted to back of head. Small skin tear to top of left hand, bleeding controlled. Slurred speech and confusion started prior to his fall. He was noted to have a delayed responses and incomprehensible words on arrival which had changed from his recent admission to this facility. Stroke code called on arrival at 4:08 p.m. and sent to have CT.</p> <p>ED provider note date of service 7/2/25 at 9:42 p.m., identified R1's computed tomography (CT) scan (imaging using x-ray techniques to create detailed images of bones, blood vessels, and soft tissues inside the body) and angiography combined a CT scan with the injection of dye (CTA) returned results indicated unclear if he had pneumonia or congestive heart failure (CHF), hospital treatment was needed.</p> <p>Review of the motor vehicle driving records (MVR) lacked evidence NA-A had been cleared before 7/2/25. (cleared on 7/3/25, after incident).</p> <p>During an interview on 7/15/25 at 1:40 p.m. family member (FM) stated R1 had a change in condition and facility staff suggested he be sent into ED. She was unable to transport him in her car due to the size of his oxygen tank, so the facility offered to transport him in the facility van. She left facility to meet them at the hospital, drove the long way around towards the hospital, after when she turned the corner saw the facility van pulled over on the side of the road and NA-A stood outside the van sobbing, and stated he fell over. She looked in the van and saw him positioned in the wheelchair on his back with his legs up in the air, head turned to the left side, located up against the back seat. He was awake and unaware of what had happened. She positioned herself at his feet by the front of the van and NA-A was positioned at his head. Together they pulled the wheelchair to an upright position. When asked what happened she stated she thought they did not strap in the front wheels. FM stated she encouraged her to calm down and breath, NA-A was distraught and scared. The skin located on the top of his left-hand was peeled back from the wrist to his knuckles and blood ran down his hand. She stated it was a freak accident and hoped the facility can figure out what happened so that it does not happen to someone else.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 4</p> <p>During an interview on 7/16/25 at 10:48 a.m., nursing assistant (NA)-A stated she had not heard of a facility van orientation/education and or received any education regarding the safe transporting of a resident in the facility van. On 7/2/25, she transported two residents and to the best of her ability, used all straps provided to keep them safe. She transported a female resident (R3) earlier in the day on 7/2/25. R3 was positioned in the back of the van in a wheelchair with brakes on, all four tie down straps (two in front and back) and the seat/lap belt across her chest and abdomen area. She was randomly asked to transport the first resident to urgent care and then received a call to come back to facility to transport R1. When she arrived back at facility, RN-A pushed R1 out to the van in a wheelchair, placed him into the van and in the passenger spot. She locked his brakes and walked back into the facility. NA-A indicated she normally would place residents in the back of the van. She drove 10 miles an hour for about one block before pulling over to the side of the road where she reached over to R1 and pulled two straps on quickly, attached tie down straps located on the floor of the van, one in front and one in back to the wheelchair. She kept driving, then after the gravel road, turned left onto the highway to the hospital and in the middle of the turn he fell backwards in the wheelchair. The oxygen tank was heavy, located on the back of his wheelchair, and may have had something to do with the fall. He fell on top of the oxygen tank. She pulled over to the side of the road and waved down family member (FM) when she drove by. We lifted R1 in his wheelchair up to a sitting position. The front tie down had let loose. He had no bleeding on his head and had a skin tear on his left hand.</p> <p>During a follow-up interview/observation on 7/17/25 at 2:16 p.m., NA-A and surveyor went out to the facility van. NA-A stated the front passenger spot did not have the front connection for the seat beat located on the floor when she transported R1 to the hospital on 7/2/25. She pointed out an approximately 12-inch extension (seat/lap belt would have been attached to). Observation showed the extender was attached to the floor of the van was located up by the passenger spot on the left side of where the wheelchair would be placed. She stated one tie down was used in front and back of the wheelchair and should have tighten them, the one on the right front was not working and had been fixed since. He would have not fallen backwards if she would have had the right connection to the seat/lap belt and tightened the tie downs to the wheelchair. She was unaware of any special training/education, had seen</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 5 other staff take the van and go, so she did not question it.</p> <p>During an interview on 7/15/25 at 3:37 p.m. activities director (AD) stated the van had a safety inspection completed by the department of transportation (DOT) on 7/11/25, prior to that she was unsure when it had been completed. She had provided van use education to approximately five staff for 2024 (unsure of date) and used the bus orientation check list. She physically demonstrated the tie downs and seat/lap belts in the bus. She was responsible to have provided the education/bus orientation check list to staff annually prior to driving the van to properly know how to secure a wheelchair and transport the resident safely. She was unsure if NA-A had completed the education. A motor vehicle driving record should have been checked annually on staff prior to driving the van and would have been expected to be completed by the administrator. She was unsure if NA-A driver's record was checked prior to 7/2/25.</p> <p>During a follow-up interview on 7/17/25 at 2:04 p.m., AD stated she had developed a more detailed safety check list for the van/bus and most likely will be completed by maintenance. The monthly safety checks had been completed by herself and used one form for both. She was unable to identified which vehicle was checked and if there had been an issue/concern due to only one check mark placed by each area looked at. She stated a separate safety check sheet for each vehicle would be used in the future. She had removed the floor extension belt (connected to the wall seat/lap belt) each time she placed a resident into the van or removed them. The floor extension belt connector was placed in the back of the van.</p> <p>During an interview on 7/17/25 at 9:29 a.m. interim DON/RN-A and corporate RN-E were both present. DON stated any staff driving the facility van or bus should have had a driving record checked and received the bus orientation prior to transporting a resident. DON stated NA-A was not included on the van driver list and transported two residents by facility van on 7/2/25. She was unsure if NA-A's driver's record report or education had been completed prior to 7/2/25. NA-A had reported to her she had not filled out the driver record check paperwork and would have been important to had made sure she had a valid driver's license and no tickets. NA-A had not received the bus orientation /education and should have.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 6</p> <p>During an interview on 7/17/25 at 11:15 a.m. administrator stated the van was used to transport residents for outings, social events and appointments. On 7/2/25, The staff instructed NA-A to come back to the facility to get R1 and should have first verified NA-A had skills/knowledge to transport residents in a wheelchair in the van. It would have been critical to ensure we are transporting our residents safely. The nursing staff sent an unqualified driver without education to transfer residents in the van in the wheelchair and R1's accident could have been prevented. A second person could have confirmed the proper straps were attached as required and the fall could have been prevented. There were no safety checks completed by DOT on the van prior to 7/11/25. Monthly bus/van driver safety checks had been completed and verified seat belts were working and accessible. NA-A had transported R2 in the van in her wheelchair earlier in the day on 7/2/25, later in the day NA-A transported R1 in the van in his wheelchair. Both residents while being transported sat in the passenger spot, the four-point straps were there, available and in place it be used. NA-A only used two straps, one in the back and one in the front of the wheelchair. The seat/lap belt extender (should have been located on the floor of the van) was not placed and later found a brand new one in the back of the van still in the package. The proper use of the seat/lap belt and the four point tie downs could have prevented R1 from tipping backwards and hopefully forward, and the fall on 7/2/25. Without the bus orientation education, she would have not known to have looked in the van for the seat/lap belt extension. R1's situation was a medical emergency and should have been transported to the hospital in the ambulance. The charge nurse asked NA-A to transport R1 to the ED without asking the DON or administrator for verification. Van keys were kept in activity office and if an NA was told to go get them they would. NA-A had not completed the education or driving record checked prior to her transporting two residents in wheelchairs in the van on 7/2/25. The social worker designee (SWD) had transported residents in wheelchairs in the van, unsure as to how often, without receiving the required education and driving record checked since May 2025. All vehicles were removed from usage immediately following the incident.</p> <p>During an interview on 7/17/25 at 2:45 p.m. Q'Striant sales engineer representative (SEP) stated when a resident was transported in a van the four point die downs must be used to be kept safe. Without the use of</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 7 the four tie downs, the resident would be placed at a higher risk for the wheelchair to tip over, flip backwards, and injury. The lap/seat belt was required to be used with all transfers and without the belt being applied placed the resident at risk for sliding and/or falling out of the wheelchair. Education and training for staff working with transporting a resident in a wheelchair in a van would help minimize many issues such as lack of knowledge that can create a lot of problems such as misuse of the system and help prevent injuries and accidents.</p> <p>Manufacturers Q'Straint user instructions undated, identified wheelchair must be placed facing forward in securement area, apply wheel locks/ turn power off. Attach tie-down anchorages and ensure they are locked in. Attach the four tie-down hooks to solid frame members or weldments, near seat level. Ensure tie-downs are fixed at approximately 45 degrees. Do not attach hooks to wheels, plastic, or removable parts of wheelchair. Ensure all tie-downs are locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs (if present) to take up additional webbing slack. Secure passenger: attach lab belts using integrated stiffeners (plastic end) to feed belts through openings between seat backs and bottoms, and/or armrests to ensure proper belt fit around occupant. On aisle side, attach belt with female buckle to rear tie down pin connector, ensuring buckle rests on passenger's hip. On the window-side attach belt with make tongue to rear tie-down pin connector and insert into female buckle. Attach shoulder belt- extend shoulder belt over passenger's shoulder and across upper torso and fasten pin connector onto lap belt. Note: combination lap/shoulder belts serve as both window-side lab belt and shoulder belt. Ensure belts are adjusted as firmly as possible but consistent with user comfort.</p> <p>Facility policy Use and Maintenance of Company Vehicles undated, identified for the business needs of the organization, there may be times when an employee is asked to operate a vehicle by the company. Employees are responsible to know that they are held to the state standards, rules, and regulations. The employees must have a valid and current driver's license to operate a company vehicle, or a personal vehicle with current auto insurance while on company business. Employees are expected to drive in a safe and responsible manner and to maintain a good driving record.</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245592	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER OAKLAND PARK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 123 BAKEN STREET , THIEF RIVER FALLS, Minnesota, 56701	
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F0689 SS = SQC-J	<p>Continued from page 8</p> <p>Facility policy Facility Assisted Transportation 7/2025 identified it was the policy of this facility to ensure access to safe, non-emergency transportation to doctor's appointments, activity outings, and other trips deemed necessary. This may include use of local transportation, taxis, ambulance (for emergent or stretcher transfer) and/or facility van or bus when appropriate. The van will be well-maintained and equipped with proper safety features. This included wheelchair restraints which will be used according to manufacturer instructions. The van will also have required safety inspections with records being maintained by the facility administrator, or designee. All residents transported using the facility van/bus in a wheelchair will be properly secured using a 4-point harness and seatbelt to include shoulder harness and lap belt. Only staff who are authorized and listed on the facility insurance may drive/operate facility vehicles. Staff authorized to drive the van/bus will have training specific to Strain restraint system and be able to return demo proper restraint and seatbelt use. Staff authorized to drive the van/bus will have necessary training and licensure to operate the vehicle as well as knowledge of van safety features. Training records will be kept in the employee's file. Staff authorized to drive the bus will be aware of emergency procedures. If an emergency arises during transportation, the driver will pull over as soon as safe to do so and call 911 for assistance. This includes both medical and behavioral emergencies as well as any accidents. Travel liability in the facility van/bus will have details logged in binder in the vehicle to include miles, driver, safety checks, and date/time.</p> <p>The past noncompliance immediate jeopardy began on 7/2/25. The immediate jeopardy was removed 7/2/25, and the deficient practice corrected after the facility implemented a systemic plan that included the following actions:</p> <ul style="list-style-type: none"> -Facility bus and van were immediately removed from use. -DOT inspection completed and passed for bus and van. -The lap belt extender was located and installed. -Two staff that have been trained on van/bus policies and procedures, completed online training/competency checked, and MVR checked will be allowed to hold the keys and/or transport residents. 	F0689		

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F0689 SS = SQC-J	<p>Continued from page 9</p> <p>-Keys have been stored in locked box and can be unlocked by a 4-digit code known by only the facility administrator, cooperate RN, and DON. Keys must be checked out prior to vehicle use.</p> <p>-New policy was written Facility Assisted Transportation and facility policy Use and Maintenance of Company Vehicles was brought to the facility from the corporation.</p> <p>-Activities director and activities assistant received Q' Straint online training and return demo of knowledge.</p> <p>-A new MVR report and transportation log was created and will be used.</p> <p>-An all-staff meeting was scheduled for end of July 2025.</p> <p>R2's annual MDS dated 5/12/25, identified intact cognition. She required supervision/touching with transfers/walking with the use of a walker and required the use of a wheelchair for mobility. She required the use of oxygen.</p> <p>During an interview/observation on 7/16/25 at 11:34 a.m., R2 laid on top of her bed with oxygen on per nasal cannula (NC) at 3 L. When she left her room, her portable oxygen was placed in a small carrying case and positioned on the back of the wheelchair secured in a black bag. R2 indicated she required the use of the wheelchair when transported in the van or bus and walked with assistance. She usually sat in the passenger spot in the van and enjoyed that. She used the van once every couple weeks. Two weeks ago, she used the van and viewed in town showing of beautiful yards on the edge of town. The activities driver applied a strap to hold the front of the wheelchair, unsure if it was one or two straps, and she was unable to see how the back straps were attached. No seatbelt was applied in either the van (passenger spot or back of van) or bus when she was transported. She stated it seemed strange that she did not have a seat belt on and most likely should have.</p> <p>R3's quarterly MDS dated 4/25/25, identified intact cognition. Walks independently and used a manual wheelchair for mobility.</p> <p>During an interview on 7/16/25 at 10:00 a.m., R3 stated</p>	F0689		

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F0689 SS = SQC-J	Continued from page 10 she used her wheelchair when she went out of building and utilized the van. A couple of weeks ago on 7/2/25, she was transferred to the clinic by NA-A. She was hooked up to four of those straps located on the floor of the van to the wheelchair and no seat belt was used. She was a very careful driver but thought it would be important to make sure she as safe with a seat belt. She does not go out much but when taken out in the bus and van by AD the wheelchair was strapped down and seatbelts were not used, for sure, every time she went for a ride. She indicated they had been unable to go out for activities lately though.	F0689		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2025

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

Re: Event ID: 5CXM11

Dear Administrator:

The above facility survey was completed on July 17, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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

Minnesota State Department of Health

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 7/15/25, through 7/17/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaints were reviewed: H55928969C (MN00114396) with no licensing order issued.</p>	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		