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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review, the facility failed to contact the resident's physician of medication administration omissions for 1 of 3 resident (R1) reviewed who did not receive medications as ordered. Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], identified she was admitted to the facility from an acute hospital 1/15/26. R1's care plan dated 1/16/26, identified she had a recent diagnosis of CVA. Staff were directed to administer medications as ordered and report abnormal labs and/or vital signs to primary care provider. R1's Hospital Discharge summary dated [DATE], identified discharge diagnoses left-side posterior cerebral artery (PCA) stroke territory infarct (affecting the left temporal-occipital lobe as well as thalamus area), hyperlipidemia (high cholesterol levels), hypertension (HTN) (high blood pressure), arteriosclerotic disease, hypokalemia (low potassium), urinary tract infection (UTI), and deep vein thrombosis (DVT) prophylaxis. Hospital course: hypokalemia felt to be related to Lasix (diuretic) (removes excess fluid from the body). Patient will be on potassium supplements for approximately a month. Potassium could be discontinued if levels are normal. Medication list at discharge: potassium chloride 10 milliequivalent/liter (mEq/L) oral two times a day. She was discharged from hospital to nursing home on 1/15/26 at 1:37 p.m.R1's Hospital labs completed from 1/11/16 through 1/15/26, identified: -On 1/11/26 Comprehensive Metabolic Panel (CMP) collected at 1:56 p.m.: Potassium 3.5 mEq/L (reference range 3.5 to 5.1 mEq/L)-On 1/15/26 CMP collected at 7:02 a.m.: Potassium 3.1 mEq/L (low).Interagency Transfer Orders dated 1/15/26 at 10:10 a.m., R1's medication administration report from 1/13/26 through 1/15/26, identified: -Potassium Chloride 20 mEq (start 1/15/26at 8:15 a.m. and end 1/15/26 at 8:14 p.m.) 20 mEq every three hours' times four doses for potassium level 3.0 to 3.3. Administered 1/15/26 20 mEq po at 8:34 am. (three doses ordered were not given). -Stop taking these medications: Furosemide (Lasix), mirabegron (relaxes muscles of the bladder), omega-3 fatty acids, oxybutynin (decreases overactive bladder), ubiquinone-10 (antioxidant supplement used to treat congestive heart failure), valsartan-hydroCHLOROthiazide (used to treat HTN), and vitamin C (supplement). R1's hospital interagency handoff report dated 1/15/26 at 10:16 a.m. identified: lab results CMP collected at 7:02 a.m. and updated at 9:06 a.m. Potassium 3.1 mEq/L (low).E-prescription interface dated 1/15/26 at 10:27 a.m. provided the following information: identifying provider hospital MD. Pharmacy: local pharmacy listed. Associated diagnosis: Hypokalemia. Placing order: 1/15/26 at 10:27 a.m. Outpatient medication detail: Potassium 10 mEq CR tablet. Route: take one tablet by mouth two times a day orally. Sent to pharmacy as: potassium chloride 10 mEq CR tablet. Class: E-prescribing. Order: 1151425090. Date/Time Signed: 1/15/26 at 10:27 a.m. E-prescribing Status: receipt confirmed by pharmacy on 1/15/26 at 10:28 a.m.Pharmacy packing slip dated 1/15/26, time not indicated, identified potassium chloride 10 mEq extended release (ER) tablets (14) was delivered to facility. Trained medication assistant (TMA)-A's signature (unreadable and verified by DON) was located at bottom of document. R1's progress note (continued on next page)

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.

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

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 1/18/26, identified:-At 3:06 a.m. Communication: Order found in electronic medical chart - Potassium Chloride 10 mEq by mouth 2 times a day. Hypokalemia with a level of 3.1 mEq/L. Provider identified in note to continue for a month or so, until potassium level returns to normal.-At 3:06 a.m. Order Note: The order you have entered - Potassium chloride oral packet 10 mEq. Give 10 mEq by mouth two times a day for hypokalemia.R1's order summary report dated 2/18/26, identified: -Potassium chloride oral packet 10 mEq. Give by mouth two times a day for hypokalemia. Order date: 1/18/26. Start date: 1/18/26. R1's electronic medication record (EMAR) January 2026, identified: Potassium chloride oral packet 10 mEq. Give 10 mEq by mouth two times a day for hypokalemia. Start date: 1/18/26. Administered morning and evening (twice a day from 1/18/26 through 1/28/26 (22 times). Potassium 10 mEq was administered in the morning only two days:1/23/26 (sent to ER) and1/29/26 (sent to ER/hospital).R1's primary provider initial visit at facility on 1/20/26, identified discharge summary and workup were reviewed. Medications prior to visit: potassium chloride 10 mEq one tablet (10 mEq) by mouth two times a day. Orders placed: complete blood count (CBC) with differential and glycated hemoglobin (average blood sugars over the past two to three months). Potassium level was not ordered.R1's ER visit dated 1/23/26, identified [AGE] year-old with recent diagnosis of stroke and limited ability to communicate. She had an unwitnessed fall at nursing home, presented with an obvious deformity to right ankle, and no sensation to the right side of the body from her stroke. Clinical impressions: closed trimalleolar fracture of right ankle/unwitnessed fall. Current outpatient medications on file: potassium chloride 10 mEq controlled release (CR) take one tablet by mouth two times a day. While in ER on [DATE] at 3:06 p.m. potassium level was checked, and result was 3.8 mEq/L.R1's Emergency Department (ED) Report dated 1/29/26, identified: -Active problems: hemiparesis and other later effects of CVA. -Fall at nursing home. -hyperkelemia (high potassium level) -Hypernatremia (high sodium level) -Acute Renal Failure -Severe Dehydration Family reported R1 has not had anything to drink or eat over the past three days. Current outpatient medication on file prior to encounter: Potassium 10 mEq CR tablet one po two times a day. CMP lab results Potassium 7.2 mEq/L (high) (reference range 3.5 to 5.1).Facility Medication Error document identified: medication error date: 1/15/26 at 8:00 p.m., prepared by DON. Incident description: potential medication error from day of admission on [DATE] through 1/18/26. Order was not included on discharge orders (DC) listing; however, potassium was sent from pharmacy. This was possibly not reported right away to charge nurse, and resident potentially missed three doses on evening of 1/15/26, two doses on 1/16/26, two doses on 1/17/26. Medication started on 1/18/26. Potassium level completed at hospital on 1/23/26, was within normal limits (WNL). No injuries observed at time of incident or post incident. Agency/people notified: no notifications found. Remainder of document was left blank and date completed was not identified.During an interview on 2/19/25 at 11:57 a.m. RN-A stated the TMA would have been expected to communicate with the treatment nurse as soon as the potassium was delivered from pharmacy and not listed on the EMAR. RN-A was unaware of R1's medication error until 1/18/26, when RN-A found the order during the night shift on 1/17/26 A provider was not contacted and should have been the following morning, it would have been important if R1 had side effects and/or re-check labs. R1's potassium level was below normal range at 3.1 mEq/L when admitted on [DATE], would be at the discretion of the primary provider to recheck labs.During an interview on 2/19/26 at 2:41 a.m. RN-D stated she usually worked the night shift starting at either 8:00 p.m. or 10:00 p.m. RN-D stated it was her job on the night shift to go through the medications in the cart and verify they were dated. She found R1's potassium medication card untouched and no medications removed from it in the medication cart. This was a red flag and investigated it. She searched for R1's hospital medical record only a few of the staff RN's have access to and (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not easy to find. She knew there had to be an order for R1's potassium, pharmacy would not send it to the facility without one. She located a note written by the hospital MD which had written R1 should be placed on potassium with an order. She printed the order, scanned it into R1's medical record, entered it into her facility orders and EMAR, and wrote a progress note. She verified the order was written and released on 1/15/26. The provider was not notified due to it being in the middle of the night when discovered. When the pharmacy delivered medication and no order was found, it should have been looked into further right away. She followed the facility process, turned the information over to RCC and she would have notified the provider and investigated why this happened.During an interview on 2/19/26 at 10:52 a.m. primary provider medical doctor (MD) stated she was not aware of R1 missed doses of potassium. She had not initiated provider coverage with her until she completed her first visit on 1/20/26. The nurse should have followed the facility's protocol and would have been expected to notify either the prescribing provider or the provider on call if after hours. This would have been important because missed doses of potassium with lab value below normal range would affect the patient's health. R1 could have had cardiac issues such as arrythmias (irregular heartbeats), increased tiredness/confusion, and weakness. A follow up potassium level would be indicated depending on the symptoms they are having. MD stated when she saw her on 1/20/26, R1 was unable to speak but able to answer yes or no questions by nodding. That could have been used to determine if she was having symptoms and vitals were stable. During an interview on 2/19/26 at 11:31 a.m. TMA-A stated a TMA or nurse were able to verify and accept medications from the pharmacy. She received the medications delivered by pharmacy on 1/15/26, compared them to the delivery slip one by one, and signed the document. She administered R1's medications on the EMAR and noted the potassium (delivered that day) was not listed on there. She stated this happened frequently/multiple times and in the past, she placed the medication and a note on CC's desk, then reminded the mediations were to be kept locked up in medication room. She was instructed by CC to place the medication on the counter in the medication room with a note and CC followed up on them. On 1/15/26, she did not administer the potassium and placed it on the counter with a sticky note on it and CC occasionally followed up with her. Unsure if that was done this time due to being off work for the next three days sick and then going on medical leave. TMA-A stated R1's missed doses of potassium from 1/15/26 through 1/17/26, would have been considered a medication error.During an interview on 2/19/26 at 1:50 p.m. DON stated nursing would have been expected to have notified the provider on Monday morning and that was not done. It would be important so that the provider could have assessed the situation, changed things and/or order labs to be completed.Facility policy Notification of physician and family dated 10/2017, identified Physicians, responsible family members or legal representatives shall be notified, in a timely manner, of any changes in resident's condition. The following procedure will be used as a guideline for timely notification of changes in status, changes in treatment, incidents, accidents, and/or lab results. Definition of altering treatment: if a resident's treatment, medication or care plan is altered significantly due to adverse consequences, discontinuation or existing treatment or medication or beginning of a new treatment or medication. Altering treatment significantly: if the primary physician was not the source of the treatment change, they will be notified via phone message per clinic policy within 24 hours or the first business day following the change.

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement standards of practice to ensure an assessment was completed to safely use of a lift chair for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm when R1 had an unwitnessed fall from the lift chair and sustained a trimalleolar fracture (a severe, unstable ankle injury involving fractures of three distinct bones: the lateral malleolus (fibula), medial malleolus (tibia), and posterior malleolus (back of the tibia)) with lateral subluxation of the talus (high-energy trauma (falls) forcing the foot into severe eversion.) R1 was sent to the emergency room (ER) via ambulance and required medical evaluation and treatment. The facility implemented corrective action, so the deficient practice was issued at past non-compliance.Findings include:R1's Hospital Discharge summary dated [DATE], identified discharge diagnoses left-side posterior cerebral artery (PCA) stroke territory infarct (affecting the left temporal-occipital lobe as well as thalamus area). She was found falling at home, having difficulty getting up, brought to the ER and evaluated extensively. She was found to have right upper extremity weakness as well as difficulties with coordination and was discharged from hospital to nursing home on 1/15/26 at 1:37 p.m.R1's admission Minimum Data Set (MDS) dated [DATE], identified she was admitted to the facility from an acute hospital on 1/15/26. R1 had slurred or mumbled words, responded adequately to simple, direct communication only, impaired vision, disorganized thinking, and severely impaired cognition. She had impairment of upper and lower extremities on one side and used a wheelchair for mobility. R1 was dependent upon staff for all cares including dressing, hygiene, transfers, and unable to walk. She had a medical history of stroke and urinary tract infection. She had one fall prior to admission to facility.R1's Morse Fall Scale (a tool used to assess risk for falling) dated 1/15/26, identified she had fallen previously, bedrest/wheelchair, nurse assist for mobility, and mental status identified overestimates or forgets limits regarding own ability to ambulate to bathroom. Fall risk score was 55 (low risk 0-24, moderate risk 25-44, and 45 or higher high risk) and indicated high risk for falling.R1's occupational therapy evaluation dated 1/15/26, identified she had no right sided control, unable to weight bear on right lower extremity and right knee tends to buckle, and required maximum assistance of two with standing. Trialed PAL (patient assist lift) lift and did not do well due to inability to control right upper extremity. Recommendation Hoyer lift for transfers. R1's physical therapy evaluation dated 1/19/26, identified Clinical Impressions: R1 demonstrated what appeared to be significant expressive and receptive aphasia (damage to parts of the brain causing impaired expression and understanding of language as well as reading and writing). She had weaknesses, especially the right knee buckled and right upper extremity, poor core control/leans to the right, poor safety awareness, and need for assistance for all transfers and mobility. R1 Current baseline: sit to stand transfers required moderate to maximum assistance and transfer from wheelchair/bed/wheelchair baseline was Hoyer lift.R1's care plan dated 1/16/26, identified she was at risk for falling and impaired mobility related to right side deficit related to stroke, osteoporosis, history of falls, weakness, osteoarthritis of both knees, and non-ambulatory. Staff were directed to follow therapy recommendations for ambulation and transfers, transfer with a Hoyer lift and assist of two, fall risk assessment completed upon admission, quarterly and as needed, and call light within reach always when in room. R1 was alert and oriented to person, had poor decision-making abilities, impaired safety awareness, impaired speech, unable to consistently communicate needs/unclear speech, impaired hearing and vision, and unable to remove self from a harmful situation. Staff were directed to re-orientate R1 as needed and anticipate needs.R1's progress noted from 1/21/26 (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	through 1/24/26, identified: -On 1/21/26 at 10:18 a.m. alert and oriented to self, communicates with staff, needs anticipated, and transfers with Hoyer. -On 1/23/26 at 4:16 p.m. an outside worker notified director of nursing (DON) R1 was on the floor in her room around 1:40 p.m. DON and care coordinator registered nurse (RN)-A went to room and assessed. Upon entering, R1 was on the floor laying on her right side, lift chair was all the way up. R1 stated she had tried to get on hands and knees when asked what happened. She denied pain. Upon rolling her onto her back her right foot was noted to have eversion (a movement where the sole turns outward, away from the body's midline) with noticeable deformity at medial ankle and bruising. R1 had a deficit to entire right side of body related to recent cerebral vascular accident (CVA) (stroke) prior to admission. Nursing assistants (NA) reported she had just been placed in her recliner around 1:30 p.m., offered to be placed in bed, and stated she preferred to be in the recliner. R1 was placed in chair, reclined all the way back, covered with a blanket, and chair remote moved to the left side of the chair, and hung-over left arm of chair. Family was contacted as well as emergency medical system (EMS). R1 left facility via ambulance with necessary paperwork at 2:15 p.m.-On 1/24/26 at 10:03 p.m. Circulation, motor, and sensory (CMS) Assessment: Surrounding skin is dry/intact and warm to touch. Capillary refill less than two seconds. Petal [sic] pulses present and faint. Color and temperature appropriate. No sensation in limb due to stroke.R1‘s ER visit dated 1/23/26, identified [AGE] year-old with recent diagnosis of stroke and limited ability to communicate. She had an unwitnessed fall at nursing home, presented with an obvious deformity to right ankle, and no sensation to the right side of the body from her stroke. Clinical impressions: closed trimalleolar fracture of right ankle/unwitnessed fall. A closed reduction was completed, and a splint was applied. An external referral to orthopedics was placed for surgical repair. R1‘s x-ray of right ankle dated 1/23/26, identified fractures involving distal fibular metadiaphysis (the flared, neck-like portion of the lower fibula located just above the growth plate (physis) and the ankle joint usually resulting from ankle twisting or trauma), medical malleolus (bony bump on the inside of your ankle), and posterior malleolus of the distal tibia (critical for ankle stability). There is lateral subluxation of the talus relative to the distal tibia by 1.5 centimeters (cm) (A displacement of this magnitude (15 mm) is well beyond the typical threshold of 1-4 mm used to define significant instability, often requiring urgent evaluation and intervention). Calcaneal spurring is present. Soft tissue swelling is noted about the ankle. Impression: Trimalleolar fracture with lateral subluxation of the talus.Facility internal incident report dated 1/23/26, identified R1 was found on floor in her room, laid on right side, lift chair noted to be all the way up, and right foot to have eversion with noticeable deformity at medial ankle. R1 was unable to give description of incident. Immediate action taken, called 911, family contacted, transported to hospital for further evaluation. Internal investigation was completed. Chair was taken out of use immediately and removed later that day by family. Injuries observed at time of incident: suspected fracture of the right inner ankle. Mental Status: oriented to person only. Injuries report post incident: no injuries observed post incident. Predisposing environmental factors: None. Predisposing physiological factors: confused, gait imbalance, impaired memory, and other - in working lift chair, right side deficit to upper and lower extremities related to previous CVA.R1's Orthopedic Clinic Progress Note dated 1/28/26, identified pre-operative examination. She had a mechanical fall that resulted in a fracture dislocation (trimalleolar) of her right ankle. The fracture was reduced and placed in a splint. Unfortunately, she had a stroke two weeks ago and left her with significant hemiparesis on her right side. Under normal circumstances she would benefit from open reduction internal fixation but given her level of function and recent stroke that seemed to be a very risky way to go about managing this with (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	little reward. The best option was to place her in a big bulky cast to protect the soft tissue to help fracture blisters recover and reassess her in two weeks' time. If she demonstrates recovery over time, we could potentially fix it in a delayed fashion or do a retrograde nail. If she demonstrates more skin breakdown, instability, and pain, she may benefit from an amputation. In the meantime, she was placed on strict non-weight bearing on the effected extremity.Facility five-day report dated 1/29/26 at 11:56 p.m., identified R1 was assisted into an electric recliner in her room that family had brought to the facility. She had not been assessed for use of the chair. Family indicated that the electric recliner was bought at a local store and delivered a day or two after she was admitted to the facility. Family had not explicitly told anyone they had got the chair, but staff knew about it because they had assisted her to sit in it prior to the day of the incident. R1 did not use a chair like this at home, and they believed the chair would be convenient for their mother. R1 was offered toileting and placed in the electric chair with feet elevated, covered in a blanket and remote draped over the left side of the arm rest to ensure it was not at risk for being sat on or wedged between the cushions. RCC had not been notified by family or staff of the chair being brought into the facility. RCC reported that when a resident had a lift chair, an assessment was completed by either therapy or an RN before a resident was allowed to use the chair to ensure safety. Upon admission on [DATE], R1's cognition was identified as severely impaired, high risk for falls, right sided paralysis/weakness and new cognitive deficits. Conclusion of the investigation identified the allegation was substantiated: R1 sustained a fall with injury while using an electric recliner brought into the facility without notification to administrative staff. Actions were taken because of the allegation: electric recliner was immediately removed from use and family removed the chair the evening of the incident. Care plan was updated to include resting in bed only when in her room. Audits of all rooms were completed on 1/23/26 to identify all electric recliners. All residents with functional electric chairs had completed assessments. A memo was placed out to staff: any new electric recliner must be reported immediately for proper assessment before use. A new form had been created for inclusion in the admission packets warning family/residents of potential dangers of electric equipment and instructions for notification to administration before bringing them to the facility. A designee will audit rooms once a week on an ongoing basis to ensure no new electric chairs have been brought to the facility without notification/assessment.Caregiver education dated 1/23/26, provided by therapy, identified transfers/bed mobility: Hoyer with assist of three. Ensure right lower extremity was fully supported. Do not use recliner. Be sure to avoid any weight bearing /twisting to the lower right extremity.Memo dated 1/26/26, Attention nursing staff: The only residents (5 listed) who are cleared to use electronic [sic] chairs/lift chairs. Any other lift chairs that are in the facility MUST remain unplugged. If you see a *new* chair, please be sure to pass that information on to DON or RCC immediately. We must assess before residents can use them for purposes of safety.New form added to admission packet titled Risks Associated with Power Recliner Chairs undated, identified cognitive impairment: individuals with cognitive decline may struggle to operate power recliner chairs safely. There have been documented cases where users activated the chair lift mechanism without understanding the consequences, leading to falls, and serious injuries, and including death. Unsupervised use: many users may operate these chairs without supervision, increasing the risk of accidents. Individuals may inadvertently push buttons on the remote control, causing the chair to tilt or rise unexpectedly which can lead to falls. Recommendation for Safety: Assessments by professionals - it is crucial for OT or RN assess the safety of power recliner chairs for individuals especially those with cognitive impairments. This includes evaluating the user's ability to operate the chair and understand the risks (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	involved. Education and Training: Care givers and family members should be educated about the risks associated with power recliner chairs and trained in how to assist users safely. Supervision: Users, particularly those at higher risk, should not use power recliner chairs unsupervised. Caregivers should be present to assist with operations and to respond quickly in case of an emergency. Summary: power recliner chairs can provide significant benefits for mobility and comfort but can also carry risks that must be carefully managed to prevent serious injuries or fatalities, particularly among vulnerable adults. If family would like to bring a lift chair, please ensure you let social services/DON, or administrator know so that the resident can be properly assessed by therapy.During an interview on 2/18/26 at 12:14 p.m., care coordinator RN-A stated R1 was admitted on [DATE], post stroke, alert, oriented to self only, impaired cognition with periods of clarity, one minute aware of what was going on around her and the next minute quicky forgotten. R1 had no strength on entire right side of her body, unable to bear weight on right leg or stabilize self to stand, flailing right arm, and transferred with a Hoyer lift. Staff were expected to inform her, an RN or the DON when family brought in the lift chair and was not done. We were unaware R1 had a lift chair. R1's family informed us after the fall they brought in a lift chair on 1/16/26 or 1/17/26. Facility staff started using it right away for six to seven days without a lift chair assessment. The staff nurse would have been expected to know a lift chair assessment should have been completed prior to use to make sure the resident knew how to use the remote safely, did not get stuck, fall or injured especially with impaired cognition. RN-A stated on 1/23/26, she was made aware R1 was on the floor when DON came to her office. Together they went to R1's room and found her on the floor between the bed foot board and the lift chair, slightly rolled onto her right side, and right foot totally reversed. R1 was alert, confused, talked about how she wanted to see her friends, tried to get onto her knees, and unable to provide a clear report as to what happened. The lift chair footrest was down, and chair was upright all the way to the stand-up position. RN-A stated R1 would not have been safe using the lift chair independently due to her impaired cognition, inability to have removed herself from the chair safely without assistance. The fall was unwitnessed but most likely caused by when the lift chair was raised up to the standing position, unable to bear weight on right leg, could not stabilize herself, no Dycem (non-slip material), slid off chair and onto the floor. R1's fall could have been prevented if the lift chair was not in her room. R1 sustain fractures to the right ankle, sent to ER for assessment, a closed reduction completed, stabilizing brace placed, and referral made to Orthopedics.During an interview on 2/18/26 at 1:58 p.m., NA-C stated she worked with R1 often, was forgetful, never tried to get out of bed/chair by herself, unable to stand/walk, right side was paralyzed from a stroke, and transferred with a Hoyer and assist of two staff. She had transferred R1 to the lift chair at least three times days before her fall. The remote was placed on her left side in the chair pocket located on the side of the chair. She was unable to remember where it was located, very confused, out of it, and unable to make decisions for herself. NA-C stated was aware a lift chair assessment should have been completed prior to use to prevent falls/injuries, and unsure if had been.During an interview on 2/18/26 at 3:25 p.m., RN-B stated R1 had poor safety awareness, dependent upon staff for all cares and transfers with a Hoyer lift and assistance of two. She stated was unsure when R1 received the lift chair however, she had worked 1/18/26, for a couple of hours and assisted another RN with a Hoyer transfer from wheelchair to the lift chair. The remote was placed on the side of the chair so that she could not use it but could have possibly reached down and grabbed it. RN-B stated she did not think of looking to look if there was a lift chair assessment and thought since it was in her room they could use it. Best way to find out would have been to contact the care coordinator or DON (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	and/or look in her electronic medical records under the assessments (lift chair). After R1 fell she realized a lift chair assessment had not been completed and should have been done prior to use by the DON or her and additionally, therapy on their end to ensure she was able to use the remote properly to prevent incidents/falls. R1's lift chair was found in the stand-up position; she slid out of the chair onto the floor and most likely would have not happened if the chair was not in there. R1 fractured her right ankle. She had received PT/OT in her room during the time the lift chair was being used. During an interview on 2/18/26 at 3:51 p.m., RN-C stated she was the MDS coordinator. R1's cognition was impaired, limited communication, unable to stand or walk and had a deficit to upper and lower right side post stroke. A chair assessment should have been completed by an RN prior to use to ensure she was safe to use the chair and would have helped prevent falls. The root cause analysis and interdisciplinary team (IDT) determined R1 was not safe to be in a lift chair, got a hold of the remote, pushed it, chair went up, fell out of chair, and fractured her right ankle in multiple spots. If the remote had been placed out of R1's reach she would have been safe, she was unable to get out of the chair by herself.During an interview on 2/18/26 at 4:30 p.m., NA-A stated R1 started using a lift chair right after she was admitted . R1 was confused, forgetful, and unable to stand or walk due to a stroke. The family requested she be placed in the lift chair to get more rest. She had transferred R1 many times during at least two shifts she worked with from the wheelchair or bed into the lift chair using a Hoyer lift and assist of two. NA-A stated R1's care plan and care sheet identified she was safe to be in the lift chair and if not, the nurse would have let us know. There was a staff nurse (unsure of her name) aware she had the lift chair, assisted with R1's transfer out of the lift chair days before her fall. NA-A stated on 1/23/26, at approximately 1:20 p.m. with assistance of NA-B, R1 was transferred with a Hoyer lift from wheelchair to bed, checked and changed, then transferred from bed to lift chair. R1's feet were lifted up with the lift chair remote, pillow placed under her right arm, covered with a blanket, call light positioned close by, and the lift chair remote was hung over the left arm rest, not secured to anything, so that she was able to reach the cord, pull it up to get to the remote, and usually how it was placed when she was in the lift chair. NA-A assisted another resident and not long after that R1 was seen on the floor, usure who found her or what caused the fall, and sent to ER. Looking back, R1's cognition was poor/impaired, and she would not have been safe using the remote to the lift chair alone. NA-A stated a chair lift assessment would be important to be completed prior to using the chair to ensure R1 was safe and understood how to use the chair.During an interview on 2/19/26 at 8:55 a.m., physical therapy assistant (PTA) stated he had assisted PT with the initial evaluation on 1/19/26, and R1's cognition was impaired, unable to follow cues without external support and poor memory. PTA completed three stands with R1 that lasted 18, 23, and 14 seconds, with maximum assistant, and identified R1 lacked trunk control and had severe leaning to the right side. He used a blocked technique to her right knee to decrease the risk of buckling, unable to stand or walk alone. R1 was a Hoyer lift transfer with assist of two staff. PTA stated the facility and therapy were unclear as to who should have completed the lift chair assessment. PTA indicated during the initial PT evaluation on 1/19/26, he was aware R1 was seated in a lift chair and used the remote to lower her feet down. Additionally, he saw her three times after that date: 1/20/26, she was seated in the lift chair, 1/21/26, and 1/22/26, she was in a wheelchair. PTA stated R1 would not have been safe in a lift chair and handling a remote independently due to her impaired cognition, confusion, poor memory, and right-side deficit of lateral control, right knee buckling and placed her at a higher risk for falls. The lift chair assessment should have been completed prior to use and if not, the lift chair should have been unplugged so that the lift part could (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	not be used or removed from the room to help prevent falls.During an interview on 2/19/26 at 10:50 a.m., medical doctor radiologist (R) stated R1's right ankle x-ray completed on 1/23/26, identified Trimalleolar fracture (three areas) of her ankle. R1's fractures were new and mostly likely occurred from her fall on 1/23/26.During an interview on 2/19/26 at 10:52 a.m., primary provider medical doctor (MD) stated she completed the initial visit to see R1 on 1/20/26. R1 had a massive stroke unable to move anything on her right side/care for herself and unable to communicate or eat. It was sad to see her in that condition. R1 would not have been able to safely use the lift chair independently. The cause of her fall was 1/23/26, she was confused, tried to get up by herself and fell on the floor. Her fall could have been avoided. A fracture/fall can affect the mortality rate of an elderly person: over 50 % of the elderly people that have had a stroke will die from falling.During an interview on 2/19/26 at 12:44 p.m., physical therapist (PT) stated she completed R1's initial PT evaluation via telehealth on 1/19/26, with physical therapy assistant (PTA) in the room assisting. R1's cognition was impaired, unable to answer past medical history questions, and required tactile and verbal cues. R1 sat in the lift chair during the evaluation and the PTA used the remote to elevate her feet back up at the end of the assessment. PT stated she was unsure if R1 had access to the remote that day. According to OT documentation and email correspondence the initial assessment was completed by OT on the day of admission 1/15/26, the lift chair was not there, brought in after the admission date, and therefore did not trigger them to complete an assessment for a lift chair. PT stated was the first time she had seen R1 and did not complete a lift chair assessment. Generally, nursing would be expected to notify OT to complete a lift chair assessment prior to use, for safety reasons: make sure they know how to use and manage the remote control to avoid falls. R1 had right side weakness both upper and lower, instability in right knee, and poor core strength. She was unable to stand alone, sit alone on edge of chair/leaned backwards, and transferred with a Hoyer lift. R1 would not have been safe using a lift chair. PT stated she had impaired cognition and lacked knowledge to pick up the remote. Based on her assessment on 1/19/26, being in a lift chair placed R1 at a high risk for falls and injuries.During an interview on 2/19/26 at 1:30 p.m., family member (FM) stated R1 had never used a lift chair and was not familiar with it prior to when they brought the chair to her room on either 1/16/26 or 1/17/26, after her admission on [DATE]. FM stated the family thought R1 would be more comfortable in the recliner since she had slept in recliner (not a lift chair) at home. We were informed upon admission that any furniture could be brought in and did not think it was necessary to ask staff if a lift chair would be ok. Staff saw us deliver the lift chair and placed her in it right away with the Hoyer lift. FM stated when she visited on a day shift there was a nurse (unsure of name) noted the lift chair was moving and stated staff needed to make sure the remote was placed over the arm of the chair because when she slept accidentally pushed it when she moved, remote was located next to her body. FM stated after that day she noted during visits the remote hung over the left arm of the chair, never saw it in a pocket of the chair, was unaware there was a pocket. On the day of R1's fall she was called and informed your mom must have wanted to get up and fell. FM informed the caller her mother did not have the ability to get up and move. FM stated R1 was unable to reach the remote control, very tired/sleepy, and would not purposefully try to get up or able to use the remote to the lift chair.During an interview on 2/19/26 at 1:50 p.m., DON stated either an RN, floor manager, DON, or therapist would be expected to assess a resident prior to the use of a lift chair to make sure they are safe, appropriate for use, and care planned to prevent injuries. R1 was not assessed prior to the use of the electric lift chair because we were not aware the chair was here. R1 would not have been safe or cleared to use or the electric chair due to her stroke that left her (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	with cognitive and physical deficits and no previous experience with a lift chair. DON stated she was not made aware R1 had a lift chair. On 1/23/26, staff NAs had placed R1 in the lift chair approximately five minutes before she was seen on the floor in her room by a vendor and then notified her. The fall was unwitnessed and R1 was unable to explain what happened. DON stated she thought R1 had started setting up the chair with the remote, most likely did not understand what happened and slid out of chair onto the floor. R1 sustained an injury, a trimalleolar fracture to the right ankle. During an interview on 2/19/26 at 2:40 p.m., NA-B stated R1 had impaired cognition and memory, and most likely unable to remember she could not stand independently. Most days it was hard to hold a conversation with her. R1 was transferred via Hoyer due to right side paralyzed due to stroke. On 1/23/26 at approximately 1:20 p.m. R1 requested to go into her lift recliner after lunch. NA-B stated NA-A assisted with a check and change and the transfer via Hoyer to the lift chair. NA-A used the remote to elevate her feet and recline her back in the lift chair. The remote was placed in the left side chair pocket out of reach by NA-A. R1's television turned on, covered with a blanket and call light placed within reach. Ten minutes later NA-B walked by R1's room and noted she was located on the floor with staff assisting her. R1's lift chair was positioned in the upright stand position. R1's cognition was not intact enough for her to use the lift chair remote, may have thought it was the TV remote instead and she would not have raised the chair up all the way to stand. Prior to R1's fall, unsure if a chair lift assessment should have been completed prior to use or if one was completed. The lift chair was placed in her room right after admission and she had used it at least seven times prior to fall. R1 was sent to ER and sustained a fractured ankle in three places. She had received education since fall and made aware of the importance of the lift assessment to be completed prior to use to prevent falls.Facility policy Fall Prevention and Reduction Program dated 1/2021, policy implemented to use a fall prevention and reduction program to provide prompt treatment and prevent further injury. A total score of 45 or greater on the fall risk assessment was considered high risk for potential falls and shall result in the implementation of appropriate fall prevention interventions related to cognitive status, medical condition, and identified in care plan. Fall Prevention Protocols may include but are not limited to: PT/OT safety or positioning screens, evaluations and/or treatment, rocking chair, Merri walker, ect., and other.Facility policy Electric Recliner dated 6/2021 and 2/2026, identified Policy: to keep the residents, other residents, and staff safe the resident's ability to properly operate and electric recliner will be evaluated by the therapy department, or a registered nurse and ongoing use will be observed for appropriateness by the facility staff. Purpose: to safely provide the residents with increased independence and mobility. Procedure: staff at the facility will observe the residents for any unsafe operation of the electric recliner. If a resident was found to be operating the electric recliner unsafely and putting themselves at risk, staff will fill [sic] report to the RCC or DON. Unsafe use will be discussed by the administrator, DON, RN's and department heads at morning meetings to determine what the proper action is. Resident maybe elevated by the therapy department or RN again at a time staff feel it is appropriate, or resident may not be safe to continue use.Corrective Action was implemented by 1/26/26, before survey entrance on 2/17/26, therefore the deficiency was issued at Past Noncompliance.

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure 1 of 1 resident (R2) reviewed for medication errors was free of significant medication errors when orders for Potassium (electrolyte that carries an electrical charge to balance fluids in the cells, contacts muscles including the heart and transmits nerve signals to the brain) was not transcribed into the electronic medical record according to physician's orders and resulted in at least six missed doses of Potassium 10 milliequivalent (mEq).Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], identified she was admitted to the facility from an acute hospital 1/15/26. R1 had slurred or mumbled words, responded adequately to simple, direct communication only, impaired vision, disorganized thinking, and severely impaired cognition. R1's medical included history of cerebral vascular accident (CVA) (stroke) and urinary tract infection (UTI).R1's care plan dated 1/16/26, identified she was at nutritional risk due to aphasia (a sudden neurological language disorder caused by brain damage) recent loss of independence, and mechanically altered diet. Staff were directed to provide assistance with eating and water pitcher be brought to her room twice daily to provide hydration and decrease risk for dehydration. R1 had a recent diagnosis of CVA. Staff were directed to administer medications as ordered and report abnormal labs and or vital signs to primary care provider. R1's Hospital Discharge summary dated [DATE], identified discharge diagnoses left-side posterior cerebral artery (PCA) stroke territory infarct (affecting the left temporal-occipital lobe as well as thalamus area), hyperlipidemia (high cholesterol levels), hypertension (HTN) (high blood pressure), arteriosclerotic disease, hypokalemia (low potassium), urinary tract infection (UTI), and deep vein thrombosis (DVT) prophylaxis. Hospital course: hypokalemia felt to be related to Lasix (diuretic) (removes excess fluid from the body). Patient will be on potassium supplements for approximately a month. Potassium could be discontinued if levels are normal. Medication list at discharge: potassium chloride 10 mEq oral two times a day. She was discharged from hospital to nursing home on 1/15/26 at 1:37 p.m.R1's Hospital labs completed from 1/11/16 through 1/15/26, identified:-On 1/11/26 Comprehensive Metabolic Panel (CMP) collected at 1:56 p.m.: Potassium 3.5 milliequivalent/liter (mEq/L) (reference range 3.5 to 5.1 mEq/L)-On 1/15/26 CMP collected at 7:02 a.m.: Potassium 3.1 mEq/L (low).Interagency Transfer Orders dated 1/15/26 at 10:10 a.m. R1's medication administration report from 1/13/26 through 1/15/26, identified: -Furosemide (Lasix) tablet 20 milligrams (mg) daily per mouth (po) start date 1/12/26. Administered on 1/13/26 at 10:08 a.m., 1/14/26 at 9:43 a.m., and 1/15/26 at 8:34 a.m.-Potassium Chloride 20 mEq (start 1/15/26at 8:15 a.m. and end 1/15/26 at 8:14 p.m.) 20 mEq every three hours' time four doses for potassium level 3.0 to 3.3. Administered 1/15/26 20 mEq po at 8:34 am. (three doses ordered were not given).-Stop taking these medications: Furosemide (Lasix), mirabegron (relaxes muscles of the bladder), omega-3 fatty acids, oxybutynin (decreases overactive bladder), ubiquinone-10 (antioxidant supplement used to treat congestive heart failure), valsartan-hydroCHLOROthiazide (used to treat HTN), and vitamin C (supplement).R1's hospital interagency handoff report dated 1/15/26 at 10:16 a.m. identified: lab results CMP collected at 7:02 a.m. and updated at 9:06 a.m. Potassium 3.1 mEq/L (low).E-prescription interface dated 1/15/26 at 10:27 a.m. provided the following information: identifying provider hospital MD. Pharmacy: local pharmacy listed. Associated diagnosis: Hypokalemia. Placing order: 1/15/26 at 10:27 a.m. Outpatient medication detail: Potassium 10 mEq CR tablet. Route: take one tablet by mouth two times a day orally. Sent to pharmacy as: potassium chloride 10 mEq CR tablet. Class: E-prescribing. Order: 1151425090. Date/Time Signed: 1/15/26 at 10:27 a.m. E-prescribing Status: receipt confirmed by pharmacy on 1/15/26 at 10:28 a.m.Pharmacy packing slip dated 1/15/26, time not indicated, identified potassium chloride 10 mEq extended (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	release (ER) tablets (14) was delivered to facility. Trained medication assistant (TMA)-A's signature (unreadable and verified by DON) was located at bottom of document.R1's progress note dated 1/18/26, identified:-At 3:06 a.m. Communication: Order found in electronic medical chart - Potassium Chloride 10 mEq by mouth 2 times a day. Hypokalemia with a level of 3.1 mEq/L. Provider identified in note to continue for a month or so, until potassium level returns to normal.-At 3:06 a.m. Order Note: The order you have entered - Potassium chloride oral packet 10 mEq. Give 10 mEq by mouth two times a day for hypokalemia.R1's order summary report dated 2/18/26, identified: -Potassium chloride oral packet 10 mEq. Give by mouth two times a day for hypokalemia. Order date: 1/18/26. Start date: 1/18/26.R1's electronic medication record (EMAR) January 2026, identified:-Potassium chloride oral packet 10 mEq. Give 10 mEq by mouth two times a day for hypokalemia. Start date: 1/18/26. Administered morning and evening (twice a day from 1/18/26 through 1/28/26 (22 times). Potassium 10 mEq was administered in the morning only two days:1/23/26 (sent to ER) and1/29/26 (sent to ER/hospital).R1's primary provider initial visit at facility on 1/20/26, identified discharge summary and workup were reviewed. Medications prior to visit: potassium chloride 10 mEq one tablet (10 mEq) by mouth two times a day. Orders placed: complete blood count (CBC) with differential and glycated hemoglobin (average blood sugars over the past two to three months). Potassium level was not ordered.R1's ER visit dated 1/23/26, identified [AGE] year-old with recent diagnosis of stroke and limited ability to communicate. She had an unwitnessed fall at nursing home, presented with an obvious deformity to right ankle, and no sensation to the right side of the body from her stroke. Clinical impressions: closed trimalleolar fracture of right ankle/unwitnessed fall. Current outpatient medications on file: potassium chloride 10 mEq controlled release (CR) take one tablet by mouth two times a day. While in ER on [DATE] at 3:06 p.m. potassium level was checked, and result was 3.8 mEq/L.R1's Emergency Department (ED) Report dated 1/29/26, identified:-Active problems: hemiparesis and other later effects of CVA.-Fall at nursing home.-hyperkelemia (high potassium level)-Hypernatremia (high sodium level)-Acute Renal Failure-Severe DehydrationFamily reported R1 has not had anything to drink or eat over the past three days. Current outpatient medication on file prior to encounter: Potassium 10 mEq CR tablet one po two times a day. CMP lab results Potassium 7.2 mEq/L (high) (reference range 3.5 to 5.1).Facility Medication Error document identified: medication error date: 1/15/26 at 8:00 p.m. prepared by DON. Incident description: potential medication error from day of admission on [DATE] through 1/18/26. Order was not included on discharge orders (DC) listing; however, potassium was sent from pharmacy. This was possibly not reported right away to charge nurse, and resident potentially missed three doses on evening of 1/15/26, two doses on 1/16/26, two doses on 1/17/26. Medication started on 1/18/26. Potassium level completed at hospital on 1/23/26, was within normal limits (WNL). No injuries observed at time of incident or post incident. Agency/people notified: no notifications found. Remainder of document was left blank and date completed was not identified.During an interview on 2/18/26 at 12:14 p.m. care coordinator (CC) RN-A stated R1 was discharged from the hospital and admitted to the facility on [DATE]. R1's discharge orders dated 1/15/26 from the hospital did not include a potassium order but were included in the hospital notes. The hospitalist provider reviewed R1's labs and placed an order for potassium after discharge from the hospital (unsure of what date/time). Depending on the escribe date/time, the order should have gone through the pharmacy and usually the provider or the nurse would have contacted us. RN-A had no idea the provider added the order. On 1/17/26, RN-D was working night shift looked through provider notes and identified the order.During an follow-up interview on 2/19/25 at 11:57 a.m. RN-A stated the TMA would have been expected to communicate with the treatment nurse. She had not received a sticky note or notification from TMA-A (was the old way of (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doing things and working on changing that so it did not happen again), was unaware of R1's medication error until 1/18/26, when RN-A found the order.During an interview on 2/18/26 at 3:51 p.m. RN-C stated when a resident was admitted to the facility from a hospital the paper portfolio usually included a discharge summary and orders. It would be an expectation for the staff nurse to complete the admission to review those documents and any other ones sent from the hospital to get a full background on the resident, current problems/concerns, and discharge orders. When a medication was received from the pharmacy and no order was identified the nurse or TMA would be expected to have notified the charge nurse right away so that it could be investigated and medication errors are avoided.During an interview on 2/19/26 at 2:41 a.m. RN-D stated she usually worked the night shift starting at either 8:00 p.m. or 10:00 p.m. RN-D stated it was her job on the night shift to go through the medications in the cart and verify they were dated. She found R1's potassium medication card untouched and no medications removed from it in the medication cart. This was a red flag and investigated it. She searched for R1's hospital medical record only a few of the staff RN's have access to and was not easy to find. She knew there had to be an order for R1's potassium, pharmacy would not send it to the facility without one. She located a note written by the hospital MD which had written R1 should be placed on potassium, and an order. She printed the order, scanned it into R1's medical record, entered it into her facility orders and EMAR, and wrote a progress note. She verified the order was written and released on 1/15/26. When the pharmacy delivered medication and no order was found, it should have been looked into further right away. She followed the facility process, turned the information over to RCC. The CC would have notified the provider and investigated why this happened.During an interview on 2/19/26 at 10:15 a.m. pharmacy tech stated R1's releasing order information form was used as an e-prescription and placed in the system on 1/15/26, when ordered by the provider. She was unaware how that was received by the nursing home facility and verified R1's potassium 10 mEq tablets (16) were delivered on 1/15/26, unsure what time.During an interview on 2/19/26 at 10:52 a.m. primary provider medical doctor (MD) stated she was not aware of R1 missed doses of potassium. She had not initiated provider coverage with R1 until she completed her first visit on 1/20/26. The nurse should have followed the facilities protocol and would have been expected to notify either the prescribing provider or the provider on call if after hours. This would have been important because missed doses of potassium with lab value below normal range would affect the patient's health. R1 could have had cardiac issues such as arrythmias (irregular heartbeats), increased tiredness/confusion, and weakness. A follow up potassium level would be indicated depending on the symptoms they are having. MD stated when she saw her on 1/20/26, R1 was unable to speak but able to answer yes or no questions by nodding. That could have been used to determine if she was having symptoms and vitals were stable. During an interview on 2/19/26 at 11:31 a.m. TMA-A stated a TMA or nurse were able to verify and accept medications from the pharmacy. She received the medications delivered by pharmacy on 1/15/26, compared them to the delivery slip one by one, and signed the document. She administered R1's medications on the EMAR and noted the potassium (delivered that day) was not listed on there. She stated this happened frequently/multiple times and in the past, she placed the medication and a note on CC's desk, then reminded the mediations were to be kept locked up in medication room. She was instructed by CC to place the medication on the counter in the medication room with a note and CC followed up on them. On 1/15/26, she did not administer the potassium and placed it on the counter with a sticky note on it and RCC occasionally followed up with her. Unsure if that was done this time due to being off work for the next three days sick and then going on medical leave. TMA-A stated R1's missed doses of potassium from 1/15/26 through 1/17/26, would have been considered a medication error.During an (continued on next page)

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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Park Communities, Inc.	123 Baken Street Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 2/19/26 at 1:50 p.m. DON stated she was unaware of what documents were received when R1 was admitted on [DATE], from the hospital. Staff would be expected to read and review the hospital summary notes and EMAR upon admission to verify that everything ordered/recommended on discharge has been implemented. The hospital summary usually was included in the hospital discharge paperwork on the day of admission but sometimes came days later. DON verified TMA-A had received and signed pharmacy slip on 1/15/26, potassium tablets were delivered to the facility. The TMA would be expected to have verified the medications received with the packing slip, placed the potassium tablets into the medication cart, and if there was not an order for the medication to communicate with the charge nurse working that evening, resident care coordinator (RCC) or DON. DON stated she preferred written or verbal communication and was informed a post it note was written and placed in the medication room along with the potassium delivered on 1/15/26. The medication remained in the medication room through many shifts. Many things went wrong: the order did not come from the provider, the next morning the pharmacy should have sent us the order, the potassium remained in the medication room on the counter left for the staff not to discover, discrepancy with the medication, and not placed in the eMAR. There should have been a follow up by nursing on 1/15/26 when the potassium arrived from the pharmacy without an order. Missed doses of potassium would be considered a medication error. DON stated she was made aware for the first time yesterday of the medication error by surveyor, completed a medication error report, and had not fully investigated the situation yet. DON stated on 1/17/26, during the night shift RN-D found the potassium on the counter in the medication room, looked on the interagency transfer orders received from the hospital, order for the medication was not on that list, logged into the hospital medical record system and found it in the medication record. The hospital provider or his nurse would have been expected to either call or fax the order to us and did not happen. That does not negate the issue on 1/15/26 and should have been followed up on 1/16/26 anyways. DON stated there was potential for harm, but no harm was identified, R1's potassium level within normal range on 1/23/26, when sent to ER to 3.8 mEq/L.Medication error policy was requested and not received.