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	12/31/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN CMS10055) and the Notice of Medicare Non-Coverage (NOMNC CMS-10123) was provided to 1 of 3 residents (R17) reviewed for beneficiary notification. Findings include: R17's quarterly Minimum Data Set (MDS) dated [DATE], identified R17 was cognitively intact. R17 was admitted on [DATE], and there was functional range of motion in both upper and lower extremities and was not receiving therapy services. R17's medical record identified R17 started Medicare Part A services on 5/22/25, and last covered day of Medicare Part A services was 7/1/25. R17's medical record that a SNFABN or NOMNC was issued to the resident. The medical record lacked evidence R17 was made aware of the cost of continuing services or on how to appeal the ending of services. During an interview on 12/30/25 at 4:26 p.m., the administrator stated the notices were to be completed by the social services designee or the MDS coordinator. The forms would be presented to the resident a couple of days prior to the last covered day. When the forms were completed, it should have been documented and scanned into the medical record. During a follow up interview on 12/31/25 at 10:23 a.m., the administrator stated they could not find documentation the forms were completed and presented to the R17. This should have been completed. The policies related to the SNFABN and NOMNC were requested, but no policies were received.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide written bed hold notice to resident/resident's representative at the time of transfer to hospital for 1 of 1 resident (R12) reviewed for hospitalizations.Findings include: R12's discharge Minimum Data Set (MDS) dated [DATE], identified R12 had an unplanned discharge with return anticipated. Diagnoses included chronic obstructive pulmonary disease (COPD), diastolic heart failure (CHF), atrial fibrillation (irregular heartbeat) and myocardial infarction (heart attack). R12's progress note dated 12/9/25, identified R12 was admitted to the hospital for fever and shortness of breath with concern of a CHF exacerbation. R12's medical record lacked evidence a written notice for bed hold was provided, that specified the duration of the bed hold, the reserve bed payment policy and the nursing facility's policies regarding bed hold periods. During interview on 12/30/25, at 2:20 p.m. the unit manager (UM)-B stated when the facility received a call from the hospital that they were going to admit a resident, they would ask the family for a bed hold. The facility did not always get the call from the hospital or would get the call after hours and then it would be done the next day. Bed holds were usually done on the phone verbally and then would be documented and scanned into the resident's chart. UM-B was not sure why a bed hold notice had not been completed for R12. When interviewed on 12/30/25, at 3:53 p.m. the director of nursing (DON) stated she had been unable to find a signed or verbal bed hold completed for R12. A bed hold should be obtained when a resident was sent to the emergency room or hospital, and staff should have them sign one before they left the facility in case they were admitted to the hospital. If it was not obtained before a resident left the facility and the facility received notification the resident would be admitted to the hospital, the charge nurse was to call the family and obtain a verbal bed hold. A bed hold should have been obtained for R12; however, it had been missed. During telephone interview on 12/31/25, at 8:55 a.m. family member (FM)-C stated they had never discussed a bed hold or signed a bed hold when R12 was admitted to the hospital. R12 was able to return to the facility and her same room without any concerns or issues. The family knew R12's bed would be held at the facility because it was paid up for the month but had never been informed of the facility's bed hold policy. The facility's Bed Hold and Return for Hospital/Therapeutic Leave policy dated 7/2017, identified the facility would provide written information to the resident and/or representative about the facility's bed hold policy on admission and before a resident was transferred to the hospital or went on therapeutic leave. In case of an emergency transfer, the resident/representative would be provided with written bed hold notice within 24 hours after the transfer. The facility would hold a resident's bed for 18 consecutive days for a hospital leave. No charge would be made for those 18 days, regardless of payer source.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to revise the resident's care plan to reflect accurate behaviors and interventions to mitigate behaviors for 1 of 1 resident (R18) reviewed for behavioral health.Findings include:R18's significant change Minimum Data Set (MDS) dated [DATE], identified R18 had moderately impaired cognition. R18 required maximum assistance with dressing and grooming, dependent with toileting and transfers and was unable to ambulate. R18 exhibited physical behavioral symptoms toward others such as hit, kick, push or grab one to three times per week and other behavioral symptoms not directed toward others such as rummaging, and/or verbal symptoms one to three days per week. R18 received antipsychotic and antidepressant medications on a routine basis. Diagnoses included Alzheimer's disease, dementia, restlessness and agitation, diabetes and depression. R18's nursing progress notes identified the following:11/19/25, Seen by physician on rounds with orders to attempt GDR with sertraline. Decrease sertraline from 100 milligrams (mg) to 75 mg every day. 11/20/25, Orders received for solumedrol (a steroid to reduce inflammation) dose pack, cough syrup and doxycycline (an antibiotic) for atelectasis (part of a lung collapse) in lung bases. 11/21/25, When R18 attempted to exit the activity room, his wheelchair came in close contact with R2, who was entering the room. R2 hollered at R18 to move and called him a profanity. R18 became agitated and yelled back. Both residents closed fists came in contact with the other's shoulders. Staff intervened and separated the two residents. 11/29/25, R18 was very rude to others. Attempted to hit two other residents as they were going past him. 11/30/25, R18 was calling staff and other residents names, using profanity. 12/2/25, R18 was fighting with his tablemate R2. When staff attempted to separate the residents, R18 swung his arm out and hit R2, making contact with the other residents back of head. Staff planned to discuss new seating arrangements for the two residents involved. R18 did not attempt to seek out R2 after the incident. 12/4/25, R18 attempted to give R6 a blanket. when R6 refused, R18 called R6 a stupid bitch. When staff attempted to bring R18 to another area, R18 reached out and hit R6 in the face. When assessed later, R6 did not have any physical injury or verbalize distress. R6 did not remember the incident. 12/5/25, order was received to increase R18's Zoloft back to 100 mg a day due to failed GDR attempt resulted in increased physical and verbal behaviors, agitation and restlessness. 12/7/25, R18 was observed ramming another resident's wheelchair. Redirection was effective. 12/11/25, R18 was agitated and calling other resident's names. 12/14/25, R18 was swearing at staff and residents and calling them names.R18's care plan with revision date 12/5/25, identified R18 had a diagnosis of depression, dementia with psychotic symptoms and Alzheimer's disease. R18 had a failed gradual dose reduction (GDR) attempt on Zoloft 12/2025. Goals were identified that R18 would not have undesirable side effects of his medications, would continue to participate in self-care, participate in activities and would not harm self or others. Interventions included to observe for side effects, sleep patterns, reorientate as needed and remove from stimulating environment if became agitated. Resident specific interventions included reading book or newspaper, looking at pictures, one to one visit, involve in activities, and wander guard for wandering. Target behaviors of sexual commentary, sticking tongue out, agitation, aggression, restlessness, depression, hollering out for help, exit seeking, wandering into other's rooms, kicking wheelchairs, spitting and resistive with care. However, the care plan failed to identify a potential for, and/or actual resident to resident altercations, including triggers, and interventions to prevent or intervene adverse altercations with other residents. R18's care plan failed to identify planned seating arrangements for meals in the dining room along with interventions to keep the environment calm. On 12/30/25, at 9:11 a.m. R18 was observed sitting in the general lobby area, visiting with another male resident. R18 would holler out to people walking past, asking for Christmas candy and making general comments such as she doesn't know anything. On 12/30/25, at 2:35 p.m. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18 was observed lying in bed with television on and door of room partially open. R18 would holler out at passerby, hey get in here, come back here. R18's voice became louder and angrier, until staff went into room to speak with him. On 12/30/25, at 5:00 p.m. R18 was observed seated at dining room table with another female resident seated, eating beside him. R18 reached out with his fork toward the other resident and asked if he could have her food. The unidentified female resident stated no, you ate all of yours. This is mine. R18 attempted to obtain some of her food with his fork but returned his fork to his plate and reached for his cup of liquid to drink. When interviewed on 12/30/25, at 5:50 p.m. the director of nursing (DON) stated R18 did not tolerate the Zoloft decrease very well and things escalated quickly. With in the two weeks, staff were seeing behaviors and attributed it to the GDR on his Zoloft as well as he had been started on a steroid. Right after the medication adjustments they had started to see an escalation of his behaviors. They discussed resident incidents, behaviors, changes of condition in their daily interdisciplinary team meetings and had also done an environmental analysis at the same time. The facility had noted they had a handful of residents that were exhibiting sundowning type of behaviors with increase agitation. Staff had reported it was difficult to control the dining room at supper time because of the sundowning behaviors some residents were exhibiting. IDT had implemented a few things that also improved R18's behaviors and aggression. Staff implemented a low stimulation environment in the common area between 2:00 and 4:00 p.m., housekeeping typically vacuumed the common area around 4:00 p.m. so they stopped that as well. We dimmed the lights, use of essential oils and tried to not have all the residents congregated in that one common area when waiting for supper. The facility had even turned the issue into a quality improvement project to track the interventions and progress with the escalation of resident behaviors in the evenings. During interview on 12/31/25, at 10:00 a.m. the DON stated she received an incident report on resident-to-resident incidents. The facility looked at if there were injury or mental anguish or changes in the victim to determine if an incident was reportable. The DON discussed the incident with the nurse working at the time it occurred and visit with the victim to assess for trauma. After every incident a new interventions was implemented. Usually the interventions were documented in the resident's care plan and are in the internal risk reports as well. Interventions were also put on the aide care sheets and as a memo in the nurse aide report and the nurse report book. New incidents and interventions were also passed on in shift report. The facility made it a practice to always do some kind of new intervention following an incident. They had put interventions in place for R18 for being around other residents, encouraging him to be active in activities. When R18 was having a bad day, staff were to bring him to his room or a quiet area, as well as the environmental changes they had done to help calm residents in the evenings. The DON thought R18's care plan had been revised on 12/5/25, but it did not include resident to resident altercations or the environmental interventions implemented. When R18 was like that, having a bad day, staff knew him well enough to know when he was building. Staff knew to move him to a different area when he was more agitated or restless. The staff also knew that R18 did not respond well to the younger girls assisting him with care, so they tried to pair him with older staff members for care. Was not specific in R18's plan of care but staff knew R18 and when he had escalating behaviors. A policy for care plans was requested, however was not received.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the facility antibiotic stewardship program was followed for antibiotic use for 1 of 1 resident (R23) reviewed for antibiotic use. Findings include:R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had significant cognitive impairment. R23 required total assistance with all activities of daily living (ADLs) and was incontinent of bowel and bladder. Diagnoses included Alzheimer's disease, anxiety, and urinary tract infection (UTI).R23's progress notes identified R23 was seen in the emergency room on [DATE] for possible seizure activity. R23 was diagnosed with a UTI and Keflex (an antibiotic) was ordered 500 milligrams (MG) two times per day for seven days. R23's medical record identified the following:12/15/25, a urine sample was obtained which identified many bacteria and was set up for culture. 12/16/25, a physician progress note identified R23 was seen on rounds. The physician noted R23 had been started on Keflex to treat a UTI. Results of R23's urine culture was not documented.R23's medical record lacked evidence of any established criteria (i.e. McGeer) being used to determine the presence of infection before an antibiotic was initiated. R23's medical record also lacked urine culture results to ensure the antibiotic ordered for R23's infection was appropriate and would be effective. When interviewed on 12/30/25, at 10:35 a.m. trained medical assistant (TMA)-A stated the unit manager followed up on ordered antibiotics and would review culture results to ensure the infection was sensitive to the antibiotic ordered. The medication nurse just followed the Medication Administration Record (MAR) and administered the antibiotic as ordered.During interview on 12/20/25, the unit manager (UM)-B stated she usually followed up on urine cultures to make sure the ordered antibiotic was appropriate. Once she knows a resident had a urine sample taken, she was on high alert and had access to the residents' charts at the hospital. She usually documented in the resident progress not that she had reviewed the culture and if it was sensitive to the ordered antibiotic or not. When a urine was done in the emergency room, they kind of watch and check for culture results after a day or so. UM-B reviewed R23's hospital one chart notes and verified a culture was done and identified an organism that was sensitive to the ordered antibiotic. UM-B stated she thought the culture results had been reviewed when R23's physician had rounded at the facility the following day. Review of the culture on file identified the culture had not been finalized until 12/17/25, the day after R23 was seen by her physician on rounds. When interviewed on 12/30/25, at 11:18 a.m. the director of nursing (DON) stated the unit managers were expected to follow up on urinalysis and culture results and ensure the appropriate antibiotics were ordered. The DON would have thought UM-B would have followed up on R23's urine culture as that was her expectation and if not sensitive to follow up with the resident's primary provider. The infection control nurse then collected the data and did a summary on the review of antibiotics. The facility's Antibiotic Stewardship policy with last review date 2/2025, identified the nurse would utilize the Loeb Minimum Criteria protocols to determine if it was necessary to treat with antibiotics or if adjustments in therapy needed to be made. Physicians would be notified of results of diagnostic tests to ensure residents were taking the appropriate antibiotic of if the antibiotic needed to be discontinued or changed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits for vaccinations being offered along with offering the most recent pneumococcal vaccine for 1 of 5 residents (R21) reviewed for immunizations.Findings include:R21's quarterly Minimum Data Set (MDS) dated [DATE], identified R21 was admitted to the facility on [DATE], was [AGE] years old, had moderate cognitive impairment, and had a diagnosis of heart failure. R21's immunization record dated 12/31/25, identified R1 had a historical record R1 had received the pneumovax vaccination on 10/23/02. However, R21's medical record failed to identify R21 or R21's representative was provided the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal.During an interview on 12/31/25 at 10:38 a.m., the interim director of nursing (IDON) stated a resident's immunization stated was reviewed upon admit and on a yearly basis. Documentation of is entered when immunizations were reviewed, education give, and if accepted or declined. There was no documentation in R21's medical that R21 or R21's representative had received education related to the pneumonia vaccine or if was offered.The facility's Pneumococcal Vaccine policy dated 11/2024, identified the facility would provide education related immunization and document administration or refusal of immunization.