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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0YJO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00038

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245517**

2.STATE VENDOR OR MEDICAID NO.
(L2) **206540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAKLAWN HEALTH CARE CENTER**
(L4) **201 OAKLAWN AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/26/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **77** (L18)

13.Total Certified Beds **77** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Mandatory DOPNA, effective 03/12/15 is rescinded as of 02/24/2015.

17. SURVEYOR SIGNATURE — Date :
Kathy Hahn, HFE NE II — 03/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 03/20/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: **00** (L30)

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/26/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245517
March 10, 2015

Ms. Susan Kratzke, Administrator
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, Minnesota 56001

Dear Ms. Kratzke:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 20, 2015 the above facility is certified for or recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 77 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 10, 2015

Ms. Susan Kratzke, Administrator
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, Minnesota 56001

RE: Project Number S5517026

Dear Ms. Kratzke:

On March 3, 2015, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 12, 2015. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on December 12, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on January 22, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 26, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 22, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 24, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 22, 2015, as of February 24, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 3, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 12, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 11, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 11, 2015, is

to be rescinded.

In our letter of February 3, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 11, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 24, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245517	A. Building B. Wing	2/26/2015

Name of Facility	Street Address, City, State, Zip Code
OAKLAWN HEALTH CARE CENTER	201 OAKLAWN AVENUE MANKATO, MN 56001

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	02/24/2015	ID Prefix F0226 Reg. # 483.13(c) LSC	02/24/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By JS/KJ	Date: 3/10/2015	Signature of Surveyor: 28591	Date: 2/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/12/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0YJO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00038

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245517**

2.STATE VENDOR OR MEDICAID NO.
(L2) **206540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAKLAWN HEALTH CARE CENTER**
(L4) **201 OAKLAWN AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/22/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **77** (L18)

13.Total Certified Beds **77** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Mandatory DOPNA, effective 03/12/15, is recommended.

17. SURVEYOR SIGNATURE Date :
Annette Truebenbach, HFE NE II 02/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 03/15/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/26/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1072
February 3, 2015

Ms. Stacy Kay Johnson, Administrator
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, Minnesota 56001

RE: Project Number S5517026

Dear Ms. Johnson:

On December 30, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 12, 2014 that included an investigation of complaint number H5517016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 22, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 21, 2015.

However, compliance with the health deficiencies issued pursuant to the December 12, 2014 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)38 whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- **Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 12, 2015. (42 CFR 488.417 (b))**

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 12, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 12, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Oaklawn Health Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 12, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

A copy of the Post Certification Revisit Form (CMS-2567B) from the January 22, 2015 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245517	A. Building B. Wing	1/22/2015

Name of Facility	Street Address, City, State, Zip Code
OAKLAWN HEALTH CARE CENTER	201 OAKLAWN AVENUE MANKATO, MN 56001

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **01/12/2015**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **01/12/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/12/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/12/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **01/12/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/12/2015**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **01/12/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/12/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/12/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	2/3/2015	32209	1/22/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/12/2014			

PRINTED: 02/03/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	R-C 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH CARE CENTER	201 OAKLAWN AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 000)	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on January 21-22, 2015, to determine compliance with Federal deficiencies issued during a recertification survey exited on December 12, 2014. During this revisit the following regulations were determined to be not corrected.	(F 000)	*Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.* We will continue to respect the privacy of Resident R60 by allowing her to relax unsupervised in the spa. A baby monitor has been placed in the spa room so that we can hear if the resident is in need of assistants.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	*Address how the facility will identify other residents having the potential to be affected by the same deficient practice.* Any resident who bathes independently will have a baby monitor in place. *Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur* Resident incidents will be communicated to the RN Nurse Manager or the RN on call. It will then be immediately reported to the Administrator. A decision on the reportability of the incident will be made. If deemed reportable, the incident will be submitted to the State Agency by the Administrator or the RN on call or the RN Nurse Manager. An investigation will be completed with the results of the investigation being reported to the State Agency within 5 days.	

approved 2/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Kratzke	Administrator	2/13/15

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

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

PRINTED: 02/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	R-C 01/22/2015

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OAKLAWN HEALTH CARE CENTER	201 OAKLAWN AVENUE MANKATO, MN 56001

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report and investigate an allegation of neglect for 1 of 1 resident (R60). who was left unattended in a facility bathtub for a significant period of time with the call-light activated. The facility also failed to ensure allegations of abuse/mistreatment were reported immediately to the state agency (SA) for 2 of 5 residents (R13, R2) reviewed for potential incidents of abuse/mistreatment, and failed to report the results of investigations within 5 days to the SA for 1 of 4 (R13) incidents where an investigation was conducted. Findings include: R60 was admitted to the facility on 3/10/12, with diagnosis that included but not limited to hypertension, atrial fibrillation, depressive disorder and osteoarthrosis. Health Status Progress Note dated 1/6/15, at 10:33 p.m. noted, "Resident refused her bath yesterday and got one tonight. Res was left in tub room during bath, NAR left tub room to assist with another resident and returned approx. 40 minutes later, water was cold. Resident states	F 225	*Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring corrective action is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the Quality Assurance Program.* The Abuse Prohibition plan has been updated to reflect that incidents need to be reported immediately. Education regarding this policy is scheduled for the Nursing Department on 2-18 and 2-19. Instructions on how to report incidents as a first report to the state agency and the required timelines have been written and reviewed with the Nurse Managers, Occupational Health and Learning Director, the DON and Administrator. Audits will be conducted weekly for one month to review incident reports and assure that reportable incidents are reported and reported in a timely fashion. Audits will be completed by the Administrator and/Or the Occupational Health and Learning Director. *Include dates when corrective action will be completed.* Corrective action will be completed by 2-20-15 *Date of substantial compliance:* Substantial compliance will be reached by 2-20-15.	

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F 225	Continued From page 2	F 225		

that she was yelling out but no body heard her. Res was in good mood when writer went to talk to her about incident. Writer explained what happened and that she would talk to NAR about not leaving the room even if resident is independent with bathing so this wouldn't happen again. Resident was not upset just worried about if she would be forgotten for the night and what she would do. Writer reassured her that this wouldn't happen."

R60's plan of care (POC) reviewed 1/21/15, at approximately 5:30 p.m. revealed for bathing "one assist to transfer on and off bath chair, able to wash self once in bath/shower."

The POC noted additional information was added on 1/22/15, including, "Likes to soak in tub, can leave with call light. Check frequently." "Trial use of additional communication method of baby monitor in tub room when [resident's name] takes bath. Will re-evaluate effectiveness after 3 baths."

North unit call light log revealed on 1/6/15, call was placed at 8:02 p.m. in the tub room, and staff response time was 30 minutes and 9 seconds.

When interviewed on 1/22/15, at 10:15 a.m. R60 recalled being left in the tub and calling out for help, and indicated being somewhat worried when there was no response for quite a while. R60 also stated staff typically remain in the tub room.

When interviewed on 1/22/15, at 11:15 a.m. registered nurse (RN)-A verified she had updated the plan of care that morning. RN-A stated no incident report had been completed, nor an

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F 225	Continued From page 3 investigation. RN-A stated the nursing assistant (NA)-A giving the bath had left to help another NA on the floor, and RN-A's intervention was to provide education to staff on duty when they returned the next scheduled shift, but was unable to provide documentation of this. Education included to check on the resident at least every 10 minutes, and to inform the nurse if there were only two NAs on duty. RN-A also indicated this would not have occurred if there were three NAs on duty. When interviewed on 1/22/15, at 3:00 p.m. RN-A stated she was not provided a specific time R60 was left in the tub, but NA thought it was about 20 minutes or so, and also indicated the water was cold. RN-A verified no investigation had been completed after learning of the incident. RN-A also stated looking back they probably should have reported this. When asked if R60 had any health conditions which would warrant concern with being left in the tub for this amount of time, RN-A stated R60 occasionally runs a low hemoglobin which is being monitored. When interviewed on 1/22/15, at 3:11 p.m. the administrator stated R60's daughter had stopped in her office to report the incident. A Complaint or Grievance Report was completed. The administrator also indicated discussing the incident with R60, who expressed concern about not being heard through the door of the tub room. The administrator then talked with RN-A to report the incident. The administrator noted she did not feel this was neglect or needed to be reported since everyone felt safe, there were no concerns, and R60 liked to be in the tub. She verified after being interviewed, she could understand the concern.	F 225		

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F 225	Continued From page 4 R13's quarterly Minimum Data Set (MDS) dated 11/8/14, identified her cognition was severely impaired and she required extensive assistance for most activities of daily living (ADLs) including locomotion on and off the unit. The plan of care dated 11/17/14, directed, "Foot pedals on wheelchair for transport only... Requires assist to and from some destinations... When pushing w/c [wheelchair] foot pedals need to be used for resident safety." The care plan noted the intervention of foot pedals while pushing R13 in her wheelchair were in place as early as 5/16/11. An Incident Report dated 8/18/14, revealed an unnamed employee failed to apply foot pedals to R13's wheelchair, prior to propelling her to a destination on 7/16/14 (this date was later deemed inaccurate, with the accurate date of incident being 8/17/14). The report noted, "... Foot dropped to floor catching on carpet resulting in stuck foot not moving with w/c and resident experienced her knee to become bent more than usual as resident generally has legs extended...." The report identified one NA and one nurse witnessed the incident, but the "alleged perpetrator" information section of the report was left incomplete. The facility administrator was noted as the submitter of this incident report to the SA which occurred the day after the incident. The Investigative Report which corresponded with this incident, was submitted to the SA on 8/31/14, 13 days after the initial report was submitted. During interview on 1/11/15, at 4:39 p.m. the administrator reviewed R13's electronic medical record and confirmed the above noted incident	F 225		

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F 225	Continued From page 5 occurred on 8/17/14, at approximately 7:00 p.m. She verified the date of 7/16/14, which was noted on both the incident and investigative reports, were inaccurate. The administrator indicated the NA noted as a witness on the initial incident report was actually the NA involved in the incident. The administrator could not recall why the investigative report was not submitted within the required timeframe of five working days. She was aware of the timeframe requirement, but could not offer an explanation for why the report was not submitted for 13 days post the initial report. During a follow-up interview at 5:59 p.m., the administrator confirmed she was unable to determine an explanation for why R13's investigative report was not submitted within the required timeframe. R2's annual MDS dated 1/2/15, identified she was cognitively intact and totally dependent on staff for all ADLs. Review of a progress note authored by social service director (SSD) on 10/8/14, at 11:38 a.m. revealed R2 had reported a concern of potential mistreatment to the interdisciplinary team (IDT), while at her care conference on that date. The note indicated R2 thought she may have been inappropriately touched by an unknown male resident on the Sunday prior to the care conference (10/5/14). The notes indicated R2's physical disabilities and visual deficits limited her ability to identify the male resident who touched her. R2 reported that she wanted to confirm the unknown resident was not her husband (who also resided in the facility) prior to pursuing the matter further. An Incident Report dated 10/9/14, confirmed the	F 225		

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F 225	Continued From page 6 facility administrator submitted an initial report addressing R2's concern of potential mistreatment to the SA on 10/9/14. During interview on 1/22/15, at 4:27 p.m. SSD verified accuracy of the progress note for R2 on 10/8/14. She reported the administrator was present at the care conference at the time of R2's report and to her knowledge, the administrator was going to follow up with the concern and notify the SA as per their facility procedures. SSD indicated R2's care conference likely took place at approximately 10:00 a.m. to 10:30 a.m. SSD reported she spoke with R2's husband immediately after the care conference and confirmed he was not the resident who touched R2. During interview on 1/22/15, at 4:39 p.m. the administrator verified she was present at the care conference on 10/8/14, when R2 reported a concern of potential mistreatment. The administrator reported she spoke privately with R2 immediately after the care conference to clarify the details of what had occurred on 10/5/14. The administrator confirmed she submitted an initial report of this concern of potential mistreatment to the SA on 10/9/14, the following day. The administrator was unable to explain why a report was not submitted to the SA on the same day she obtained knowledge of the concern. The administrator was unable to recall what time of day R2's care conference took place, nor what time of day the initial incident report was submitted to the SA. Facility's Abuse Prohibition Plan dated 3/14, noted the purpose was to ensure all incidents of alleged or suspected abuse/neglect were	F 225		

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F 225	Continued From page 7 promptly investigated and reported, as well as to ensure a complete review of existing incidents were documented. The policy noted all staff were responsible for reporting any situation that was considered abuse or neglect along with injuries of unknown origin, misappropriation of resident property, or involuntary seclusion. A completed incident report was to be routed per facility procedure, with the charge nurse notified immediately for assessment of the situation to determine if any emergency treatment or action was required and completion of an initial investigation. In addition, the Abuse Prohibition Plan under Notification Procedures documented, 3. Notify the Minnesota Department of Health (MDH) on the notification website WITHIN 24 hours after discovery of incident. However, the notification to the state agency is required to be immediately and not within 24 hours.	F 225	*Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.* We will continue to respect the privacy of Resident R60 by allowing her to relax unsupervised in the spa. A baby monitor has been placed in the spa room so that we can hear if the resident is in need of assistants. *Address how the facility will identify other residents having the potential to be affected by the same deficient practice.* Any resident who bathes independently will have a baby monitor in place. *Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur*	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement policies and procedures for abuse prohibition related to immediate notification of the state agency (SA). The facility failed to immediately report and investigate an allegation of neglect for 1 of 1	F 226	Resident incidents will be communicated to the RN Nurse Manager or the RN on call. It will then be immediately reported to the Administrator. A decision on the reportability of the incident will be made. If deemed reportable, the incident will be submitted to the State Agency by the Administrator or the RN on call or the RN Nurse Manager. An investigation will be completed with the results of the investigation being reported to the State Agency within 5 days.	

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F 226	Continued From page 8 resident (R60) who was left unattended in a facility bathtub for a significant period of time with the call-light activated. The facility also failed to ensure allegations of mistreatment were reported immediately to the state agency (SA) for 2 of 5 residents (R13, R2) reviewed for potential incidents of abuse/mistreatment, and failed to report the results of investigations within 5 days to the SA for 1 of 4 (R13) incidents where an investigation was conducted. Findings include: The facility's Abuse Prohibition Plan dated 3/14, noted the purpose was to ensure all incidents of alleged or suspected abuse/neglect were promptly investigated and reported, as well as to ensure a complete review of existing incidents were documented. The policy noted all staff were responsible for reporting any situation that was considered abuse or neglect along with injuries of unknown origin, misappropriation of resident property, or involuntary seclusion. A completed incident report was to be routed per facility procedure, with the charge nurse notified immediately for assessment of the situation to determine if any emergency treatment or action was required and completion of an initial investigation. The policy defined neglect as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This includes failure to provide food, shelter, health care and/or supervision. In addition, the Abuse Prohibition Plan under Notification Procedures documented, 3. Notify the Minnesota Department of Health (MDH) on the notification website WITHIN 24 hours after	F 226	*Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring corrective action is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the Quality Assurance Program.* The Abuse Prohibition plan has been updated to reflect that incidents need to be reported immediately. Education regarding this policy is scheduled for the Nursing Department on 2-18 and 2-19. Instructions on how to report incidents as a first report to the state agency and the required timelines have been written and reviewed with the Nurse Managers, Occupational Health and Learning Director, the DON and Administrator. Audits will be conducted weekly for one month to review incident reports and assure that reportable incidents are reported and reported in a timely fashion. Audits will be completed by the Administrator and/Or the Occupational Health and Learning Director. *Include dates when corrective action will be completed.* Corrective action will be completed by 2-20-15 *Date of substantial compliance:* Substantial compliance will be reached by 2-20-15.	

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F 226	Continued From page 9 discovery of incident. However, the notification to the state agency is required to be immediately and not within 24 hours. R60 was admitted to the facility on 3/10/12, with diagnosis that included but not limited to hypertension, atrial fibrillation, depressive disorder and osteoarthrosis. Health Status Progress Note dated 1/6/15, at 10:33 p.m. noted, "Resident refused her bath yesterday and got one tonight. Res was left in tub room during bath, NAR left tub room to assist with another resident and returned approx. 40 minutes later, water was cold. Resident states that she was yelling out but no body heard her. Res was in good mood when writer went to talk to her about incident. Writer explained what happened and that she would talk to NAR about not leaving the room even if resident is independent with bathing so this wouldn't happen again. Resident was not upset just worried about if she would be forgotten for the night and what she would do. Writer reassured her that this wouldn't happen." R60's plan of care (POC) reviewed 1/21/15, at approximately 5:30 p.m. revealed for bathing "one assist to transfer on and off bath chair, able to wash self once in bath/shower." The POC noted additional information was added on 1/22/15, including, "Likes to soak in tub, can leave with call light. Check frequently." "Trial use of additional communication method of baby monitor in tub room when [resident's name] takes bath. Will re-evaluate effectiveness after 3 baths."	F 226		

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F 226	Continued From page 10 North unit call light log revealed on 1/6/15, call was placed at 8:02 p.m. in the tub room, and staff response time was 30 minutes and 9 seconds. When interviewed on 1/22/15, at 10:15 a.m. R60 recalled being left in the tub and calling out for help, and indicated being somewhat worried when there was no response for quite a while. R60 also stated staff typically remain in the tub room. When interviewed on 1/22/15, at 11:15 a.m. registered nurse (RN)-A verified she had updated the plan of care that morning. RN-A stated no incident report had been completed, nor an investigation. RN-A stated the nursing assistant (NA)-A giving the bath had left to help another NA on the floor, and RN-A's intervention was to provide education to staff on duty when they returned the next scheduled shift, but was unable to provide documentation of this. Education included to check on the resident at least every 10 minutes, and to inform the nurse if there were only two NAs on duty. RN-A also indicated this would not have occurred if there were three NAs on duty. When interviewed on 1/22/15, at 3:00 p.m. RN-A stated she was not provided a specific time R60 was left in the tub, but NA thought it was about 20 minutes or so, and also indicated the water was cold. RN-A verified no investigation had been completed after learning of the incident. RN-A also stated looking back they probably should have reported this. When asked if R60 had any health conditions which would warrant concern with being left in the tub for this amount of time, RN-A stated R60 occasionally runs a low	F 226		

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F 226	Continued From page 11 hemoglobin which is being monitored. When interviewed on 1/22/15, at 3:11 p.m. the administrator stated R60's daughter had stopped in her office to report the incident. A Complaint or Grievance Report was completed. The administrator also indicated discussing the incident with R60, who expressed concern about not being heard through the door of the tub room. The administrator then talked with RN-A to report the incident. The administrator noted she did not feel this was neglect or needed to be reported since everyone felt safe, there were no concerns, and R60 liked to be in the tub. She verified after being interviewed, she could understand the concern. R13's quarterly Minimum Data Set (MDS) dated 11/8/14, identified her cognition was severely impaired and she required extensive assistance for most activities of daily living (ADLs) including locomotion on and off the unit. The plan of care dated 11/17/14, directed, "Foot pedals on wheelchair for transport only... Requires assist to and from some destinations... When pushing w/c [wheelchair] foot pedals need to be used for resident safety." The care plan noted the intervention of foot pedals while pushing R13 in her wheelchair were in place as early as 5/16/11. An Incident Report dated 8/18/14, revealed an unnamed employee failed to apply foot pedals to R13's wheelchair, prior to propelling her to a destination on 7/16/14 (this date was later deemed inaccurate, with the accurate date of incident being 8/17/14). The report noted, "... Foot dropped to floor catching on carpet resulting	F 226		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 12 in stuck foot not moving with w/c and resident experienced her knee to become bent more than usual as resident generally has legs extended...." The report identified one NA and one nurse witnessed the incident, but the "alleged perpetrator" information section of the report was left incomplete. The facility administrator was noted as the submitter of this incident report to the SA which occurred the day following the incident. The Investigative Report which corresponded with this incident, was submitted to the SA on 8/31/14, 13 days after the initial report was submitted. During interview on 1/11/15, at 4:39 p.m. the administrator reviewed R13's electronic medical record and confirmed the above noted incident occurred on 8/17/14, at approximately 7:00 p.m. She verified the date of 7/16/14, which was noted on both the incident and investigative reports, were inaccurate. The administrator indicated the NA noted as a witness on the initial incident report was actually the NA involved in the incident. The administrator could not recall why the investigative report was not submitted within the required timeframe of five working days. She was aware of the timeframe requirement, but could not offer an explanation for why the report was not submitted for 13 days post the initial report. During a follow-up interview at 5:59 p.m., the administrator confirmed she was unable to determine an explanation for why R13's investigative report was not submitted within the required timeframe. R2's annual MDS dated 1/2/15, identified she was cognitively intact and totally dependent on staff	F 226		

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

PRINTED: 02/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	R-C 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH CARE CENTER	201 OAKLAWN AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 13 for all ADLs. Review of a progress note authored by social service director (SSD) on 10/8/14, at 11:38 a.m. revealed R2 had reported a concern of potential mistreatment to the interdisciplinary team (IDT), while at her care conference on that date. The note indicated R2 thought she may have been inappropriately touched by an unknown male resident on the Sunday prior to the care conference (10/5/14). The notes indicated R2's physical disabilities and visual deficits limited her ability to identify the male resident who touched her. R2 reported that she wanted to confirm the unknown resident was not her husband (who also resided in the facility) prior to pursuing the matter further. An Incident Report dated 10/9/14, confirmed the facility administrator submitted an initial report addressing R2's concern of potential mistreatment to the SA on 10/9/14. During interview on 1/22/15, at 4:27 p.m. SSD verified accuracy of the progress note for R2 on 10/8/14. She reported the administrator was present at the care conference at the time of R2's report and to her knowledge, the administrator was going to follow up with the concern and notify the SA as per their facility procedures. SSD indicated R2's care conference likely took place at approximately 10:00 a.m. to 10:30 a.m. SSD reported she spoke with R2's husband immediately after the care conference and confirmed he was not the resident who touched R2. During interview on 1/22/15, at 4:39 p.m. the administrator verified she was present at the care	F 226		

PRINTED: 02/03/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	R-C 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH CARE CENTER	201 OAKLAWN AVENUE MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 14 conference on 10/8/14, when R2 reported a concern of potential mistreatment. The administrator reported she spoke privately with R2 immediately after the care conference to clarify the details of what had occurred on 10/5/14. The administrator confirmed she submitted an initial report of this concern of potential mistreatment to the SA on 10/9/14, the following day. The administrator was unable to explain why a report was not submitted to the SA on the same day she obtained knowledge of the concern. The administrator was unable to recall what time of day R2's care conference took place, nor what time of day the initial incident report was submitted to the SA.	F 226		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0YJO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00038

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245517**

2.STATE VENDOR OR MEDICAID NO.
(L2) **206540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAKLAWN HEALTH CARE**
(L4) **CENTER 201 OAKLAWN AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/12/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY ~~02~~ (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **77** (L18)

13.Total Certified Beds **77** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Nicolle Marx, HFE NE II 01/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 01/22/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/26/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0969
December 30, 2014

Ms. Stacy Kay Johnson, Administrator
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, Minnesota 56001

RE: Project Number S5517026

Dear Ms. Johnson:

On December 11, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the December 11, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5517016 which was substantiated.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7365

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 20, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 20, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by March 11, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 11, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an

informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

OAKLAWN
HEALTH CARE CENTER
The Thro Company

1/12/2015

Ms. Sellner,

Please find the enclosed Plan of Correction for Oaklawn Health Care Center. This plan reflects corrections to the State Survey Process Completed 12/12/2014.

Please contact me with any questions or concerns you may have. I am happy to work with you to ensure our resident needs and we regain compliance with our deficiencies.

Sincerely,

Stacy Johnson

Stacy Johnson RDN LD LNHA
Oaklawn Administrator
201 Oaklawn Avenue
Mankato, Mn 56001
507-388-2913 (P)
507-388-1235 (f)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	12/12/2014****** ~~12/11/2014~~

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH CARE CENTER	201 OAKLAWN AVENUE MANKATO, MN 56001

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation had been completed at the time of the standard recertification survey. Investigations of complaint H5517016 had been completed and had been substantiated. Deficiencies had been issued as a result of the substantiated findings at F353, F318, F323.	F 000	******per Jessica Sellner - Supervisor exit date is 12/12/2014	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the	F 156		

approved 1/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Stacy Johnson RDN LDN NHA 1/12/15 — (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 1 resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification	F 156	F156 All residents receiving Medicare benefits will receive the required 48 hour notification of non-coverage of Medicare services per facility policy. Prevention of Recurrence: • Policy practice change to include all residents receiving Medicare benefits • Updated staff education of change provided 1/12/2015. Effective Date: Practice was changed immediately. 12/12/2014. Monitoring: Audit Medicare denial completion and timeliness of denial with goal of 100% completion and a minimum of 48 hour notice monthly for 3 months. Responsible Staff: Monitoring completed by Director of Nursing or designee to ensure compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 2 agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate liability notices when skilled services ended for 2 of 3 (R27 and R98) residents reviewed in the sample for liability notices. Findings include: R27 was not provided with 48 hours notice prior to the end of skilled services. R27 was admitted to the facility on a skilled stay, on 9/9/14, for short term rehabilitation following a	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 3 hospital stay. R27 was issued a Notice of Medicare Non-Coverage which indicated skilled services would end on 9/23/14. The notice was signed by the patient's representative on 9/22/14, 24 hours before the end of skilled services. R27 discharged home on 9/24/14, per the facility nursing progress notes. R98 was not provided with 48 hours notice prior to the end of skilled services. R98 was admitted to the facility on skilled stay, on 6/17/14, for short term rehabilitation following a hospital stay. R98's medical record lacked documentation that any liability notices indicating skilled services were ending, had been provided. Review of R98's physician orders and progress notes revealed an entry completed on 7/3/14, which included R98 had been seen by the physician and was to discharge home. R98 discharged home on 7/8/14, per the facility nursing progress notes. During interview on 12/11/14, at 7:57 a.m. the administrator confirmed R98's record lacked evidence that the required notices had been provided and stated R98 had returned from the doctor with orders to discharge and proceeded to do so. The administrator also confirmed R27's notice had not been provided within the required timeframe. The facility policy entitled Notification of Medicare Non-Coverage revised 11/14, indicated when a resident was deemed no longer coverable under Medicare guidelines, a Notice of Medicare	F 156		

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F 156	Continued From page 4 Non-Coverage Letter would be issued at least two days prior to non-coverage. The policy also noted the letter would be placed in the resident's record.	F 1	F164	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 1	Resident personal privacy will be maintained per facility Quality of Life policy. Staff will assist R38 maintain full coverage when getting ready for bed and room privacy curtain will be pulled as needed to maintain privacy. R5, R105, R42 (now deceased), and R7 privacy was addressed immediately by performing insulin treatments in their rooms each blood glucose check and insulin administration. Effective Date: Practice was changed immediately. 12/11/2014. Prevention of Recurrence: • Follow-up staff education of policy and practice expectation provided 1/12/2015. • Dignity/Privacy included in yearly staff training program and Orientation Training. • Systemic practice change: residents who receive insulin or treatments requiring privacy will receive this care in their room. • Audit of medication administration process weekly for two weeks. Monthly audits for 3 months. Audit information will become part of CQI process. Responsible Staff: Monitoring completed by Occupational Health and Learning Director or designee to ensure compliance is maintained.	

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F 164	Continued From page 5 review, the facility failed to implement measures to ensure personal privacy for 1 of 1 residents (R38) observed during personal cares. In addition, the facility failed to ensure privacy was provided during blood glucose testing and insulin administration for 4 of 4 residents (R5, R105, R42, R7) in the sample who were observed during medication administration. Findings include: R38 was not provided privacy during personal cares. R38's diagnoses, according to the admission record dated 2/22/12, included Alzheimer's disease, anxiety, and legal blindness. R38's annual Minimum Data Set (MDS), dated 10/16/14, identified R38 had short and long term memory problems and cognitive skills for daily decision making was severely impaired. The MDS further identified R38 required extensive assistance of one staff for transfers, walking in room, walking in corridor, dressing, toilet use, and personal hygiene. During an observation on 12/10/14, at 7:48 a.m. NA-C was assisting R38 with personal cares. R38's bed was near the window, and his roommate's bed was near the bathroom. NA-C placed a transfer belt around R38's waist while he sat on the edge of the bed, and assisted him to stand. R38 was wearing a hospital gown, which was tangled and gathered in the transfer belt, and the back of the gown was not secured, exposing his white briefs and back. NA-C assisted R38 while he walked to the bathroom, past his roommate who was lying awake in his bed. NA-C assisted R38 with his personal cares, while he	F 164		

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F 164	Continued From page 6 was in the bathroom, and after dressing, NA-C assisted R38 to the dining room for breakfast. During an interview on 12/10/14, at 8:15 a.m. NA-C stated she didn't know if it bothered R38 to walk in the presence of his roommate, with his back and briefs exposed, "Because he doesn't really know what's going on...Do you think it should be covered?" During an interview on 12/11/4, at 8:25 a.m. registered nurse (RN)-D stated NA-C should have pulled the back of the gown together and pulled the privacy curtain to ensure privacy for R38. During an interview on 12/11/14, at 10:00 a.m. family member (FM)-B stated, "I'm sure it would bother [R38] if he knew he was being walked in front of his roommate in his underwear. He never walked in front of us at home in his underwear...He was very private." FM-B indicated the family had provided pajama bottoms and tops for R38 and the staff never put them on him. A review of the facility's policy, Quality of Life-Dignity, revised 10/09, directed, "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." R5, R105, R42 and R7 were not provided full privacy during blood glucose testing, nursing assessment and medication administration. R5's diagnosis, according to the Admission Record dated 11/25/13, included dementia, depressive disorder and diabetes. R5's quarterly MDS, dated 9/3/14, identified R5 had short and long term memory loss, and had severely	F 164		

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F 164	Continued From page 7 impaired cognitive skills for daily decision making. Also identified, R5 required extensive assistance of two staff with bed mobility, transfers, and toileting, and required extensive assistance of one staff for dressing, locomotion on and off the unit, and personal hygiene. R105's diagnosis, according to the Admission Record dated 12/8/14, included diabetes and aftercare for hip fracture. R105's admission MDS, dated 9/15/14, identified R105 with severe cognitive impairment. Also identified, R105 was independent with bed mobility, and required limited assistance of one staff for transfers, walking in room and in the corridor, dressing, toilet use, and personal hygiene. R42's diagnosis, according to the Admission Record dated 5/13/14, included diabetes, anxiety and anemia. R42's quarterly MDS, dated 12/1/14, identified R42 with short and long term memory loss, and had severely impaired cognitive skills for daily decision making. Also identified, R42 required extensive assistance of one staff for bed mobility, locomotion on and off the unit, dressing, eating, toilet use and personal hygiene, and required extensive assistance of two staff for transfers. R7's diagnosis, according to the Admission Record dated 1/6/14, included diabetes and hypertension. R7's quarterly MDS, dated 11/13/14, identified R7 had no cognitive impairment. Also identified, R7 was independent with activities of daily living. During an observation of medication administration on 12/10/14, at 7:40 a.m., RN-E wheeled R5 in her wheelchair, into the doorway of	F 164		

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F 164	Continued From page 8 the nurse's station area, where two of the facility's medication carts were stored. A dividing wall, approximately five feet in height, separated the medication carts from the common area and the west hallway to residents' rooms, but R5 could easily be seen by someone taller than the dividing wall, or standing behind R5, as there was no effort made to provide privacy for R5. RN-E poked R5's finger to check her blood sugar. RN-E then lifted R5's knee length dress up, by grabbing the hem of the dress by R5's knees, and lifting it to R5's bra line, and then pulled down the front of R5's brief to her pubic area, and explained she needed to assess a rash on R5's abdomen. While holding the front of R5's brief down, RN-E gave R5 an insulin injection in her abdomen. During an interview on 12/10/14, at 8:58 a.m. RN-E stated, "I was told that if you pull the resident behind the wall, it's okay." RN-F stated, "We've always done it that way." During an observation on 12/10/14, at 11:50 a.m. RN-E positioned R105 in her wheelchair, in the area by the medication carts. RN-E checked R105's blood sugar and then pulled up R105's shirt to expose her abdomen, and administered an insulin injection. During this time, an unidentified visitor stood near the nurse's station, and watched as RN-E gave the insulin. During an observation on 12/10/14, at 11:55 a.m. RN-F positioned R42 in his wheelchair, in the area by the medication carts, and lifted R42's shirt to give an insulin injection in his abdomen. During an observation on 12/10/14, at 12:13 p.m. R7 was seated in the area by the medication carts, facing the nurse's station and the hallway.	F 164		

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F 164	Continued From page 9 R7 could easily be observed from the nurse's station and the hallway, as RN-F checked his blood sugar and gave an insulin injection in his right upper arm. During an observation on 12/11/14, at 7:48 a.m. while R7 sat in the medication cart area, facing the nurse's station, RN-A positioned R5 in her wheelchair, facing R7 in the same area. RN-A checked R5's blood sugar and then lifted R5's shirt to give an insulin injection in her exposed abdomen, while R7 watched. During an interview on 12/11/14, at 8:25 a.m., RN-D stated, "No one can really see what's going on there. Our previous director of nursing (DON) okayed it...We've done it that way a long time." RN-D indicated the nursing staff could possibly pull the residents into the nurse manager's office to give them more privacy. During an interview on 12/11/14, at 9:28 a.m. R105 indicated it bothered her to have her shirt lifted to receive her insulin in the abdomen, while sitting in the area by the nurse's station. R105 stated, "There are people around...Yes, it bothers me but what can I do about it?" During an interview on 12/11/14, at 11:00 a.m. RN-C indicated, the area near the nurse's station where the medication carts are stored, is very congested and the nurses should be bringing the medication carts down the hallway, so the residents' cares can be done in the privacy of their room. RN-C stated providing cares in the area by the nurse's station, "Can cross the line with privacy." A review of the facility's policy, Quality of	F 164		

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F 164	Continued From page 10 Life-Dignity, revised 10/09, directed, "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures."	F 164		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop the care plan to include range of motion (ROM) services for 4 of 9 (R59, R4, R36, R66) residents reviewed for ROM. Findings include:	F 279		

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F 279	Continued From page 11 R59's quarterly minimum data set (MDS) dated 9/4/14, indicated R59 was cognitively intact and had no current functional losses of range of motion in the upper or lower extremities. R59's care plan last updated on 9/29/14, did not address therapy recommendations related to restorative nursing and ROM services. Review of the Restorative Nursing book revealed a communication note from occupational therapy (OT) dated 6/25/14, which read, "Please complete these exercises with [resident] 3x [three times] weekly for restorative nursing program." An additional noted dated 4/18/14 instructed staff to please assist R59 with seated and standing exercises which included 20 repetitions of each. R4's quarterly MDS dated 8/23/14, indicated R4 was severely cognitively impaired and had no current functional losses of range of motion in the upper or lower extremities. R4's care plan last revised on 11/26/14, did not address therapy recommendations related to restorative nursing and ROM services. Review of the Restorative Nursing book revealed a communication note from OT dated 8/7/14, which instructed staff to provide upper body ROM three times a week. Also in the book under R4's room number was directions for completing the ROM on both arms. During interview on 12/12/14, at 8:18 a.m., registered nurse (RN)-C stated therapy would pass on the communication slip to her and she in turn would put the directions into point of care (POC) and assign it to the floor staff and then	F 279	F279 Residents who demonstrate a need for Range of Motion program who have completed therapy and have recommendations to continue Range of Motion program will have programs included in resident Plan of Care. R59, R4, and R36 now have ROM programs up to date and addressed in their care plan. R66 had OT orders obtained 12/19/14. Effective Date: Practice was changed immediately 12/12/2014. Prevention Recurrence: • Follow-up staff education provided 1/12/2015 • Systemic Practice change: Process for handling ROM programs has been updated to include information entered in resident care plan, placed on resident care sheet, and triggered for completion in Point of Care charting system. Monitoring: Monthly Audit for 3 months then quarterly audit for 6 months of resident care plan, resident care sheets, ROM program entered into Point of Care documentation system, and ROM program located in restorative book. Responsible Staff: Monitoring completed by Director of Nursing or designee to ensure compliance is maintained.	

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F 279	Continued From page 12 assign it on the treatment administration record (TAR) to the nurses to ensure it was completed. RN-C stated she also updated the care sheet and the care plan. RN-C indicated concern if residents were not getting their ROM services. RN-C stated she had not been the care manager for R4 and R59 consistently, so it was possible their information was not updated due to the gap in her position. R36's annual MDS dated 9/11/14, identified R36 was severely cognitively impaired and had a functional limitation in ROM on one side of the lower and upper extremities. R36's care plan last updated on 10/2/14, did not address therapy recommendations related to restorative nursing and ROM services. Review of the Restorative Nursing book revealed a communication note from OT dated 10/29/14 which directed staff to remove left hand brace every shift and complete ROM. An additional note dated 5/15/14 gave direction to complete PROM exercises daily on both legs. During interview on 12/12/14, at 8:52 a.m. RN-A stated R36 did not have much of a range program and that, "There is no formal program." During interview on 12/12/14, at 9:07 a.m. RN-D stated she would put the restorative program on the nursing assistant care sheets, in POC and then on the TAR for the nurses to sign off on, indicating they had ensured the NA's had completed the ROM. RN-D reviewed the restorative nursing book and confirmed R36 had a daily PROM program. RN-D then reviewed the NA care sheets, the TAR, and the care plan and	F 279		

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F 279	Continued From page 13 confirmed there was no documentation regarding PROM. R66's quarterly MDS dated 11/28/14, identified R66 as being cognitively intact and requiring limited assistance with bed mobility, transferring, ambulation, and personal hygiene. Extensive assistance was needed for dressing. R66's gait was unsteady and required staff standby assistance. The MDS also indicated R66 had an impairment on left side related to a shoulder injury that occurred prior to this admission. R66's care plan last revised on 3/1/14, did not address therapy recommendations related to restorative nursing and ROM services. Review of the OT-Therapist Progress & Discharge Summary notes dated 6/09/14, indicated R66 was to remain in the facility with restorative nursing program activities three times weekly. Interview with RN-C on 12/10/14, at 8:00 a.m. confirmed R66 currently did not have a restorative program for ROM. During interview on 12/10/14 at 3:56 p.m., NA-H indicated she was not aware of a restorative program for R66. Review of the facility policy entitled, Rehabilitative Nursing Care last revised on 4/13, revealed rehabilitative nursing care would be provided for each resident admitted and designed to assist each resident to achieve and maintain an optimal level of self care and independence. The policy indicated the program would be developed and coordinated through the resident's care plan.	F 279		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assessment and adequate monitoring of skin conditions for 2 of 2 residents (R17 and R102) reviewed for non-pressure related skin conditions. Findings include: R17's diagnoses as noted on the admission record dated 5/22/14, included anxiety, dementia, generalized pain, and anemia. R17's quarterly Minimum Data Set (MDS), dated 10/23/14, identified R17 was cognitively intact and required extensive assistance of one staff for bed mobility, transfers, dressing and toilet use. During observation and interview on 12/8/14, at 5:38 p.m. R17 was noted to have an approximately 3/4 inch laceration on the back of his left hand, middle finger, on the bottom knuckle. The laceration was scabbed, and the skin around the area was reddened. R17 stated he cut it by catching his hand in the closet door. During a review of R17's electronic medical record, an incident report dated 12/3/14, at 8:15	F 309	F309 Skin Assessment-Skin Tear-Minor Break Policy will be followed and correlating documentation will be completed. R17 had skin condition monitored through 12/18/14. Skin issue was resolved based on findings of 12/18/14 clinical assessment. R102 had skin condition monitored through 12/30/14. Skin issue was resolved based on finds of 12/30/14 clinical assessment. Effective Date: Practice was changed immediately 12/12/2015. Prevention of Recurrence: • Follow-up staff education of policy and practice expectation provided 1/12/2015. • New staff training will include specific training to policy. • Systemic Practice change: Process for skin tears has been updated to include monitoring information entered into TAR for monitoring and documentation. • Monthly Audit of weekly clinical assessment for 3 months. Responsible Staff: Monitoring completed by Director of Nursing or designee to ensure compliance is maintained.	

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F 309	Continued From page 15 p.m. revealed R17 reported a skin tear on his left hand and indicated he accidentally jammed his hand in the door frame. The area was cleansed and bacitracin, a non-adhesive dressing, and gauze were applied. A review of R17's progress notes revealed no documentation of the incident. A review of the Treatment Administration Record (TAR) for 12/1/14-12/31/14 revealed no documentation or monitoring of R17's skin tear on his left hand. Included on the TAR, was a nursing order (N.O.) to complete weekly body audits and to "Chart the changes only." Documentation indicated that this was completed on 12/4/14, with no documentation to include monitoring of the skin tear on R17's left hand. A review of R17's care plan, last updated 10/21/14, revealed R17 has potential for impaired skin integrity, with an intervention to, "Follow facility protocols for treatment of injury." No documentation was found on the care plan regarding the skin tear on his left hand. A review of R17's Bath/Shower skin audit, dated 12/4/14, on the evening shift, included in the comments section, "No new concerns noted at this time." A review of R17's Bath/Shower skin audit, dated 12/11/14, on the evening shift, included, "Old skin tear that is healing (previously documented on) no s/s [signs or symptoms] of infection." During an interview on 12/11/2014, at 8:06 a.m. registered nurse (RN)-D indicated if a skin tear or bruise is found, "We do an incident report and then we monitor on the TAR." RN-D verified R17's medical record and TAR lacked documentation of the skin tear to his left hand, and stated, "We do have quite a few new nurses that may not know the process. It's kind of a learn as you go."	F 309		

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F 309	Continued From page 16 R102's diagnoses as noted on the admission record dated 6/27/14, included hemiplegia, peripheral neuropathy, and diabetes. R102's quarterly MDS, dated 10/17/14, identified R102 was cognitively intact, and required extensive assistance of two staff for bed mobility and transfers, and extensive assistance of one staff for dressing, toilet use, and personal hygiene. During observation and interview on 12/8/14, at 6:33 p.m. a pea sized scabbed area was noted on the back of R102's right hand. R102 stated he bumped it on a door. R102's family member (FM)-A was present and indicated it happened approximately two weeks ago, and stated, "It must have been bad. They even taped it shut." During a review of R102's electronic medical record, an incident report dated 11/28/14, at 7:00 p.m., included the nurse was informed by a nursing assistant that R102 had a skin tear on his right posterior hand. R102 reported he bumped it. Steri strips were applied and it was cleaned. A review of R102's progress notes revealed a note on 11/28/14, at 11:38 p.m., and another note at 11:50 p.m., describing the skin tear and the treatment. On 12/3/14, at 3:24 a.m. five days after the incident, a progress note included, "Left skin tear on R [right] hand open to air. No s/s [signs or symptoms] of infection. Skin tear almost healed." No further documentation was found through 12/11/14, regarding the monitoring of the skin tear on R102's right hand. A review of the TAR for 11/1/14-12/31/14 revealed no documentation of monitoring of the skin tear on R102's right hand. Included on the TAR, was a N.O. to complete weekly body audits and to "Chart the changes only." Documentation indicated that this was	F 309		

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F 309	Continued From page 17 completed on 12/2/14, and 12/9/14, with no documentation to include monitoring of the skin tear on R102's right hand. A review of R102's care plan, last updated 12/8/14, revealed an intervention to monitor skin integrity, however, no documentation was found on the care plan regarding the skin tear on his right hand. During an interview on 12/11/14, at 11:49 a.m. RN-C indicated R102's skin tear may have come from his watch, and the nurse applied a Steri strip. RN-C stated, when a skin tear or bruise are noted, an incident report is completed and the area is monitored until healed. The nurses document this on the TAR. RN-C verified the skin tear on R102's right hand was not included on the TAR for 11/1/14-12/31/14, and verified only one progress note regarding the skin tear on 12/3/14. RN-C indicated the staff should have included the skin tear on the TAR, and should be monitoring it until it's healed, adding, "That's part of the process." A review of the facility's Skin Tears-Abrasions and Minor Breaks, Care of policy, revised 2/14 included, "Review the resident's care plan, current orders, and diagnoses to determine resident needs...Generate 'Non-Pressure' form and complete." On 12/12/14, at 9:05 a.m. director of nursing (DON) reported the policy had changed, and the Non-Pressure form is no longer completed. The treatment of skin tears or abrasions, "Is now placed on the TAR." DON stated the policy would be updated at the next DON meeting.	F 309		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		

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F 318	Continued From page 18 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion services (ROM) were consistently provided and documented for 5 of 9 resident (R59, R36, R33, R4 and R66) who were reviewed for ROM services. Findings include: R59's quarterly minimum data set (MDS) dated 9/4/14, indicated R59 was cognitively intact and had no current functional losses of range of motion in the upper or lower extremities. Review of the Restorative Nursing book revealed a communication note from occupational therapy (OT) dated 6/25/14, which read, "Please complete these exercises with [resident] 3x [three times] weekly for restorative nursing program." An additional noted dated 4/18/14 instructed staff to please assist R59 with seated and standing exercises which included 20 repetitions of each. Review of the nursing assistant (NA) point of care (POC) documentation from 11/12/14 through 12/12/14 revealed R59 was to receive active range of motion (AROM) to both legs, seated and standing exercises (20 repetitions each) and	F 318

F318

Residents requiring Range of Motion program will have program completed per recommendation and documented per facility policy. R59, R36, R33, and R4 now have ROM programs offered daily. Staff are made aware of their programs by reviewing their care plan, resident care sheet, and have ROM program triggered for completion in Point of Care for documentation of completion and Instructions are placed in Restorative Book. R66 had OT orders obtained 12/19/14.

Effective Date: Practice was changed immediately. 12/12/2015.

Prevention of Recurrence:

- Follow-up staff education of policy and practice expectation completed 1/12/205
- Range of Motion program and practices is part of new employee orientation competencies.
- Systemic Change: ROM programs are now included in resident plan of care, entered on staff resident care sheet, and are triggered for completion of documentation in Point of Care charting system. Instructions are placed in Restorative Book.
- Cross Training of Therapeutic Recreation Staff Training provided by OT 12/31/2014

Monitoring: Monthly Audit for 3 months then quarterly audit for 6 months of resident care plan, resident care sheets, ROM program entered into Point of Care documentation system, and ROM program located in restorative book.

Responsible Staff: Monitoring completed by Director of Nursing or designee to ensure compliance is maintained.

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F 318	Continued From page 19 isometric upper arm exercised twice a day. R59 had received AROM a total of 13 times. R59's medical record lacked documentation by the licensed nursing staff which indicated ROM was being completed consistently. During observation and interview on 12/12/14, at 9:26 a.m. R59 was seated in a chair in her room. R59 stated the staff was supposed to help with the exercises, but they had only been completed a few times since admission. R59 stated she could complete some of the exercises on her own, but not all of them. Additionally, R59 stated she didn't remind or ask the staff to help her do the exercises because she thought they were short staffed and were so busy. R59 indicated she would like to do all the exercises and was worried about getting stiff if she didn't do them. R36's annual MDS dated 9/11/14, identified R36 was severely cognitively impaired and had a functional limitation in ROM on one side of the lower and upper extremities. Review of the Restorative Nursing book revealed a communication note from OT dated 10/29/14 which directed staff to remove left hand brace every shift and complete ROM. An additional note dated 5/15/14 gave direction to complete passive range of motion (PROM) exercises daily on both legs. Review of the NA POC documentation for the time period of 11/12/14 through 12/12/14 revealed R36 received ROM a total of 6 times.	F 318		

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F 318	Continued From page 20 R36's medical record lacked documentation by the licensed nursing staff which indicated ROM was being monitored to ensure consistent completion. During observation on 12/12/14, at 9:10 a.m. R36 was sitting in his wheelchair in his room. R36 had a brace on the left arm. During interview on 12/12/14, at 8:52 a.m. registered nurse (RN)-A stated R36 did not have much of a range program and that, "There is no formal program." During interview on 12/12/14, at 9:07 a.m. RN-D stated she would put the restorative program on the nursing assistant care sheets, in POC and then on the treatment administration record (TAR) for the nurses to sign off on, indicating they had ensured the NA's had completed the ROM. RN-D reviewed the restorative nursing book and confirmed R36 had a daily PROM program. RN-D then reviewed the NA care sheets as well as the TAR and confirmed there was no documentation regarding PROM on either. R33's five day MDS dated 11/6/14, identified R33 was moderately cognitively impaired and had no function losses of range of motion in the upper or lower extremities. Review of the Restorative Nursing book revealed a communication note from OT dated 7/5/14, which directed staff to complete ROM exercises with R33 three times a week. Also in the book under R33's room number was directions for completing the ROM on both arms and legs. R33's medical record lacked documentation by	F 318		

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F 318	Continued From page 21 the licensed nursing staff which indicated ROM was being monitored to ensure consistent completion of ROM.\ On 12/12/14, at 7:36 a.m. R33 was observed and interviewed in her room. R33 stated she was supposed to do exercises of both her arms and legs and tried to do them herself because the staff didn't ever offer to assist her. R33 demonstrated partial ROM exercises to her upper extremities, but neglected to complete her shoulders. R33 stated she would like to walk to exercise her lower extremities, but "No one wants to walk with me." On 12/12/14, at 7:40 a.m. NA-H stated she had never done any ROM exercises with R33. She further stated she wasn't aware of any order for ROM and that she wouldn't have time to do ROM if she did know about it. Stated that she did walk with R33 to the bathroom and back to get her up out of her chair, but not in the hallway. NA-H commented that they were usually short of staff and didn't have time to do ROM. During an interview with RN-D on 12/12/14, at 8:21 a.m. it was verified that R33 had attended physical therapy (PT) and OT but staff had not received any direction as to an ongoing program. R4's quarterly MDS dated 8/23/14, indicated R4 was severely cognitively impaired and had no current functional losses of range of motion in the upper or lower extremities. Review of the Restorative Nursing book revealed a communication note from OT dated 8/7/14, which instructed staff to provide upper body ROM three times a week. Also in the book under R4's	F 318		

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F 318	Continued From page 22 room number was directions for completing the ROM on both arms. Review of the NA POC documentation for the time period of 11/12/14 through 12/12/14 revealed R4 received ROM a total of 10 times. R4's medical record lacked documentation by the licensed nursing staff which indicated ROM was being monitored to ensure consistent completion. During interview on 12/12/14, at 7:32 a.m. NA-B was providing morning cares to R4. NA-B stated although she only had been employed by the facility for a short time, she knew ROM services were not always being done and were only completed when the staff had time. NA-B completed ROM services to R4's upper extremities per request and stated that although R4 was able to fully range both upper extremities, she was, "Stiff." During interview on 12/12/14, at 8:18 a.m., RN-C stated therapy would pass on the communication slip to her and she in turn would put the directions into POC and assign it to the floor staff and then assign it on the TAR to the nurses to ensure it was completed. RN-C stated she also updated the care sheet and the care plan. RN-C indicated concern if residents were not getting their ROM services as it would affect all parts of their wellbeing from sleep to mood. Further, RN-C stated she had mentioned to the director of nursing that a restorative aid would be beneficial, but that the facility had enough challenges getting enough direct care staff much less adding restorative staff too. RN-C, with tears in her eyes stated, people go through orientation and then they leave, "It's hard."	F 318		

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F 318	Continued From page 23 R66 had diagnoses from the medical record that included multiple falls, anxiety manifested by physical limitations, altered mobility, and limited use of left arm. The MDS dated 11/28/14, identified R66 was cognitively intact, required extensive assistance for dressing, required staff standby assistance as her gait was unsteady. An OT Discharge Summary dated 6/9/14, indicated R66 had received therapy services from 5/12/14 - 6/9/14. The summary indicated R66 was to remain in the facility with restorative nursing program activities three times a week. During observation on 12/10/14, at 7:29 a.m. R66 was assisted with putting on a shirt and pants. R66 was observed holding her left arm against her body and NA-F lifted left arm and guided it into the shirt sleeve. During the transfer R66 did not attempt any movement of her left arm and shoulder to assist with the transfer. R66 then stated her thumb and first two fingers on her left hand had been, "numb" and "tingle" since she broke her shoulder. During an interview on 12/08/14, at 04:39 p.m..with RN-C, it was verified that R66 had limited ROM of her left shoulder and arm since her admission to the facility. On 12/10/14, at 8:00 a.m. during an interview, RN-C stated she was not aware of any recommended exercises provided by therapies and that no documentation was present in the Restorative Nursing Communication Book or on the TAR being completed by nursing.	F 318		

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F 318	Continued From page 24 On 12/10/14, at 3:45 p.m. RN-C stated she had checked with OT regarding R66's recommendations and ROM program. She stated that OT recalled a list of exercises had been given to R66. RN-C stated she was not aware of any list of exercises and that nothing was in the restorative book which would indicate a plan for ROM had been setup. RN-C was interviewed on 12/11/2014, at 8:45 a.m. and verified the procedure she followed was: at the time of discharge from therapy, a notice was given to the her and also the floor nurse. This information would then entered into the POC and assigned to floor staff for completion. The order would then transcribed onto the TAR and assigned as a nursing order. The staff nurse were to follow up with the NA's daily to ensure the task was completed. RN-C verified R66 did not have any information related to ROM on either the TAR or the NA task care sheet. During an interview with NA-F on 12/10/14, at 1:51 p.m., she stated ROM didn't get done on a consistent basis because of the lack of staff and time constraints. NA-F further stated that she felt ROM, "Was definitely on the back burner." On 12/10/14, at 3:56 p.m. NA-H stated she was not aware of R66 having orders for ROM. She further verified that there was not any ROM noted for R66 on the task list. An interview was conducted on 12/11/14, at 11:28 a.m. with NA-F who verified that residents who have ROM orders are listed in the restorative book located at the nursing station. She further stated the facility didn't have a restorative aide.	F 318		

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F 318	Continued From page 25 NA-F stated that ROM didn't get done on a consistent basis, and stated, "We don't have enough staff." NA-G who was also in attendance verbalized agreement with NA-F's statement. NA-G stated she was not aware of any staff that completed ROM on a regular basis. On 12/11/14, at 9:00 a.m. the director of nursing, (DON) was interviewed and verified that she was aware ROM was not being completed as recommended per therapy. The DON further stated, she was aware the NA's were prioritizing there tasks and this was one area that was being left undone. During interview on 12/12/14, at 8:33 a.m. physical therapy assistant (PTA)-A stated the therapy department would make up the ROM program when a resident discharged from therapy. PTA-A indicated the communication slips were given to the nurse manager and put in the restorative nursing communication book. PTA-A was not aware of any difficulties the staff were having completing ROM as monitoring that after discharge was not part of the therapy's function. PTA-A added that residents were at risk for contracture if they didn't receive their ROM services. Review of the facility policy entitled, Rehabilitative Nursing Care last revised on 4/13, revealed rehabilitative nursing care would be provided for each resident admitted and designed to assist each resident to achieve and maintain an optimal level of self care and independence. The policy indicated the program would be developed and coordinated through the resident's care plan.	F 318		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 26 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and provide effective interventions to minimize the risk of falls for 1 of 5 residents (R66) reviewed for accidents. Findings Include: R66 was admitted to the facility on 2/17/14 related to falls at home and had 15 documented fall incidents between admission and 12/10/14. The electronic medical record noted R66's diagnoses to include: encephalopathy, history of falls, anxiety state, contusion of unspecified site, aftercare following joint replacement, closed arm fracture, abnormality of gait, history of traumatic brain injury and generalized pain. R66 was observed during morning cares on 12/10/14, at 7:29 a.m.. Nursing assistant (NA)-F utilized a gait belt and standby assist for ambulation to the bathroom and back to sit on the edge of her bed. R66's gait was observed to be slightly unsteady and shuffling in nature. Upon return to the bed, R66 assisted with lifting her right arm, but made no attempt to move her left	F 323	Incident Reports will continue to be reviewed by Interdisciplinary Team (IDT) per facility routine. R66 incident reports now have causal factor identified with intervention attempted. Facility is working in conjunction with family to assist resident in reducing clutter in room. Recent safety check and monitoring was completed 1/6/15. Effective Date: Practice was changed 12/19/2014 Prevention Recurrence: • Incident Report Documentation provided as staff follow up education 1/12/2015 • Systemic change: IDT practice change 12/19/2014 to include initial review of incident then includes 2nd review of to ensure causal factor and interventions are in place to prevent recurrence of incident. Monitoring: Occupational Health and Learning Director will audit incident reports quarterly to review the documentation includes causal factors and interventions. This quarterly audit will also track residents with multiple incidents. Responsible Staff: Monitoring completed by Director of Occupational Health and Learning or designee to ensure compliance is maintained.	

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F 323	Continued From page 27 arm and shoulder to assist with transfer or putting on shirt. The floor and other surfaces were cluttered with R66's personal belongings. During an interview on 12/10/14, at 7:37 a.m. R66 stated she was able to get herself out of bed, sometimes lost her balance and denied tripping on articles lying on the floor. The most recent Care Plan last updated 12/8/2014 indicated R66 at risk for falls related to (r/t) unaware of safety needs; gait/balance problems and a history of falls with fracture. Interventions included anticipate and meet needs; educate the resident and family/caregivers about safety reminders and what to do if a fall occurs; encourage participation in activities that promote exercise, physical activity for strengthening and improved mobility; ensure resident is wearing appropriate footwear when ambulating or mobilizing in w/c; physical therapy (PT) evaluate and treat as ordered or as necessary (PRN). Staff to ensure call light is within reach and encourage the resident to use it for assistance as needed; resident needs a safe environment with staff to ensure R66's room is kept well lit and clutter free with call light being kept within reach. The quarterly Minimum Data Set (MDS) dated 11/28/14, identified R66 was cognitively intact and required limited assistance for bed mobility, transferring, ambulation, and required extensive assistance for dressing, which required standby assistance as her gait was unsteady. The following Incident reports were reviewed: 1. On 12/4/14 R66 was sitting on floor next to w/c	F 323		

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	245517	A. BUILDING _____ B. WING _____	12/11/2014

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F 323	Continued From page 28 beside her bed, stated "I missed my chair". Interventions: reminders to use call-light and ask for staff assistance. 2. On 11/21/14 R66 used call light to call staff and was sitting on floor next to bed. Stated, "I was itching my eyes and I fell out of bed." Intervention: reminders to use call-light and ask/wait for staff assistance. 3. On 11/6/14 R66 put on call light, found sitting on floor. Stated, "I was just looking for my bracelet." Intervention: Staff to encourage and remind to use her call-light and ask staff for assistance. 4. On 10/28/14 R66 found sitting on floor facing bed with w/c to her right. Stated, "must have fallen asleep in my w/c." Intervention: Call light to be kept within res reach and staff to offer reminders to use call light to ask for assistance." 5. On 10/23/14 R66 found on sitting on floor beside her bed. Stated, "she was on phone with her brother to get directions for an electronic device and to plug it in, and her brother stated if she couldn't reach it to get on her knees, Stated she had followed her brother's directions." Interventions: Resident educated about transfer safety and having assistance when wanting help. Staff continue to provide frequent reminders to use her call-light and ask staff for assistance when needed,. 6. On 10/12/14 R66 found sitting on the floor between wall and toilet. Stated, " I was just trying to lean over and wipe myself when I slid off the toilet onto the floor." Intervention: encourage to use her call-light and ask for assistance.	F 323		

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F 323	Continued From page 29 7. On 10/7/14 R66 found sitting on trash can between bed and w/c. Stated, "I lost my balance and just sat down on the garbage can." Intervention: Remind to use call-light and ask for staff assistance with transfers and toileting. 8. On 8/26/14 R66 sitting on floor facing bathroom, resident did not offer description of what happened, but said she had to use the bathroom and had called for help. Resident daughter was a witness to incident. Intervention: Provided education to resident and daughter. Remind to call/wait for assistance with transferring needs. 9. On 8/21/14 R66 sitting on floor beside bed. Stated, " I got out of bed when I spilled my pop and landed on my butt." Intervention: re-directed to call and wait for staff assistance. The suggested intervention following each fall incident was to remind R66 to use the call light when the intervention was proved ineffective to prevent falls. On 12/10/14, at 1:47 p.m. during an interview, NA-G stated R66 frequently didn't ask for assistance when transferring from her wheelchair to the bed. R66 was at risk for falling due to being unsteady. During an interview on 12/10/14, at 8:00 a.m. RN-C verified R66 had experienced multiple falls and that she continued to self transfer without consistently using her call light. RN-C stated R66 was impulsive and didn't wait for assistance before attempting to self transfer. RN-C further verified that the process when an incident	F 323		

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F 323	Continued From page 30 occurred is to review at the daily meeting and assess for additional interventions. RN-C was unable to say why the ineffective intervention was continued. On 12/10/14, at 3:53 p.m. NA-H verified that R66 needed frequent reminders to use her call light. NA-H stated R66 would still self transfer at times, was unsteady with her gait and transfers and often lost her balance. NA-H further stated she was aware of the clutter in R66's room however, R66 and her daughter did not like to have personal items rearranged.	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		

F353

Facility will continue to strive to meet resident needs in a timely and dignified manner. Addressing individual needs are as follows:

R58 concern relating to call light answering. Will continue to follow up with resident to ensure this concern has been adequately addressed. One staff person is left on the unit during meal time to answer call lights.

R6 concern is relating to her call light and having to wait to use the bathroom. Resident is independent using the bathroom. Resident does have the practice to turn her call light on to alert the staff to come when able to assist her to get ready for bed. "No rush". However on bath night resident becomes anxious if staff are not on time to get her for her bath. Staff are addressing this concern with developing an evening routine to improve consistency and reduce anxiety relating to evening issues.

R57 concern relating to getting to use the bathroom timely. This West Unit is assigned specific staff person who remains on unit rather than floating throughout the South Unit to assist with more timely assistance and anwering call lights.

R65 concern relating to call light issues in the morning is addressed with the night staff person assigned to assist resident with morning cares.

R30 concern relating to call light issues is addressed by one staff person is left on the unit during meal time to answer call lights. Resident is assisted by night staff person to assist with morning cares unless resident chooses to sleep in the morning.

R102 and spouse concern regarding call light response time is addressed by the East Unit of South assigned a specific staff person who remains on the unit rather than floating throughout the South Unit. Frequency of call light reviewed and reflects resident is using his call light frequently during the overnight shift. Resident is requesting to shave, eat, drink, TV on, TV off, and will often press call light and be sleeping. Staff are checking on resident frequently throughout the night.

R125 has discharged.

R33 concerns regarding getting to the bathroom have been addressed by assigning one specific staff person to the West Unit as a primary NAR rather than floating over the South Unit.

R17 toileting concerns have been addressed by making staff aware of bowel interventions provided resident during daily communication huddles.

R127 toileting concerns have been addressed by offering and encouraging urinal every 2 hour toileting routine. Empty urinal periodically throughout the day.

R126 toileting concerns are addressed by offering resident and encouraging urinal every 2 hour toileting routine. Resident fluid status has improved since admission. Med review completed by resident PA 1/6/2015 related to dx of hypertrophy of prostate.

R7 resident concerns addressed by placing resident on assigned NAR list and updating resident care needs on sheets the NARs use for resident cares.

R11 concerns regarding evening cares related to call light issues. Issues are addressed by providing consistency of staff during each shift.

R45 is deceased.

R66 call light concerns has been addressed by assigning a specific staff person to the West Unit rather than having staff float through the South Unit.

R23 call light concerns have been addressed by assigning primary staff to the North Unit to improve continuity of care.

R60 concerns regarding bathing have been addressed by assigning primary staff to the North Unit to improve continuity of care.

R38 family member reported concerns of staffing relating to being called to assist with resident. Calling family member is part of resident care plan when resident is not responding to staff intervention of walking resident, providing food/beverages, taking resident to the bathroom, using the weighted blanket for comfort, use of lavender and warm blanket interventions. Staff will continue to offer the interventions and if anxiety is resident issue staff will continue to call family per their request and care plan to provide resident additional comfort. In addition to

further respond to family concern facility will offer and encourage an Interdisciplinary Team meeting with family to review family concerns and resident behavioral interventions.

R42 is deceased.

R4 staffing issues relating to incomplete ROM program have been addressed by including resident ROM program on staff resident care sheet, triggering the need of ROM in Point of Care charting program, and placing ROM program in resident care plan.

Prevention of Recurrence and improvement of meeting resident need: Systemic Direct Staff Intervention

- NAR list assignment
- Primary NAR program re-instated
- Cross train of staff to increase availability of staff during peak hours of need
- Dining Host/Hostess program to provide support during meal times to allow more direct care nursing staff to remain on the floor for resident care needs
- Night staff morning resident care assignments assigned as needed for resident specific needs and/or appointments
- 1/12/15 Staff Education and Training Session
- Monitor resident responses to staffing needs/changes with Resident Rounding

Responsible Staff: Monitoring completed by Director of Nursing or designee to ensure compliance is maintained.

Systemic Indirect Staff Intervention

- New HR Director/Focus will include continual hiring practices
- New staff advertising program
- NAR Preceptor program to enhance staff on-boarding program
- Call light monitoring to look for correlation of incident(s) of call light use and potential need for alternative staffing ratios to ensure we are staffing to meet resident needs at peak hours. Monitoring will be completed monthly by unit for 3 months.

Responsible Staff: Monitoring completed by Administrator or designee to ensure compliance is maintained.

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F 353	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that staffing patterns were sufficient to meet resident's needs in a timely and dignified manner for 20 of 67 residents (R58, R6, R57, R65, R30, R102, R125, R33, R17, R127, R126, R11, R45, R66, R7, R23, R60, R38, R42, R4) residing at the facility. This practice had the potential to affect 67 of 67 residents who resided in the facility. Findings include: R58's diagnoses on the care plan dated 10/12/14, included multiple myeloma and hypertension. R58's Minimum Data Set (MDS) dated 9/15/14, identified R58 had intact cognition and required limited assistance with activities of daily living (ADL's). During an interview on 12/11/14, at 9:51 a.m. R58 stated he had to wait after he put his light on and it could be 15-30 minutes. A Complaint or Grievance Report dated 7/29/14, indicated that R58 had a concern for staffing and stated, "You need more help." The follow up on the report indicated that the night aides would stay on his wing if there were two aides on (available). Review of the call light response log for the past three months indicated that R58 had waited greater than 20 minutes on one occasion. R6's diagnoses on the care plan dated 11/2/14, included chronic kidney disease and osteoarthrosis. R6's MDS dated 11/10/14, identified R6 had intact cognition and required assistance with bathing. During interview on	F 353		

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F 353	Continued From page 32 12/9/14 at 1:41 p.m. R6 stated she felt the facility was understaffed and recalled having an accident while waiting to go to the bathroom, saying she felt, "Embarrassed." R6 indicated the residents at a recent resident council meeting requested the administration staff to attend the meeting so the residents could ask why they were so short of staff. R6 expressed frustration with the administration's excuse many other facilities were having difficulty hiring too. During a follow up interview on 12/11/14, at 8:53 a.m. R6 stated, "It scares me that I have to wait so long for my light to be answered. " A Complaint or Grievance Report dated 9/26/14, indicated that R6 had made a concern for staffing known. Follow up on the report indicated that staff would be educated on the timeliness with following up with resident. Review of the call light response log for the past three months indicated that R6 had waited for > 20 minutes on 11 occasions and >30 minutes on three occasions. R57's diagnoses on the care plan dated 12/8/14, included chronic diastolic heart failure and atrial fibrillation. R57's MDS dated 8/22/14, identified R57 had intact cognition and required limited assistance with ADL's. During an interview on 12/8/14, at 10:28 a.m. R57 indicated that she did not feel there was enough nurses aids (NAs). She reported she has had to wait for up to an hour for assistance. She reported having had an accident before (urinary incontinence) and stated, "It is embarrassing." On a Complaint or Grievance Report dated 9/10/14, R57 shared a concern for not enough staff and cited having to wait 30 minutes or longer to use the bathroom. Follow up on the report indicated that the facility was in the	F 353		

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F 353	Continued From page 33 process of hiring and training nurse aids. Review of the call light response log for the past three months indicated that R57 waited for >20 minutes on nine occasions and >30 minutes on two occasions.. R65's diagnoses on the care plan dated 11/19/14, included diabetes mellitus and disorder of the urinary tract. R65's MDS dated 9/18/14, identified R65 had intact cognition and required extensive assistance with ADL's. During interview on 12/8/14, at 5:36 p.m. R65 stated the facility was very short of NAs and that he frequently had to wait 45 minutes to an hour to have his call light answered. R65 added that it was very frustrating and stated, "You put your call light on in the morning and you never know when they will get to you." A Complaint or Grievance Report dated 10/23/14 noted that R65 had a concern for staffing in the building. Follow up on the report indicated that every effort for staff hiring and retention was happening. Review of the call light response log for the past three months indicated that R65 had waited >20 minutes on five occasions and >30 minutes on one occasion. R30's diagnoses on the care plan dated 10/13/14, included hypertension and bipolar disorder. R30's MDS dated 9/18/14, identified R30 had an intact cognition and required extensive assistance with ADL's. During an interview on 12/11/14, at 9:37 a.m. R30 indicated that the facility didn't hire enough staff. She further reported that lots of times it was a half hour to get help and she had wet her pants while waiting. "It's degrading when	F 353		

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F 353	Continued From page 34 that happens." A Complaint or Grievance Report dated 10/27/14, noted that R30 had a concern for staffing. Follow up of that report indicated that every effort for staff hiring and retention was happening. Review of the call light response log for the past three months indicated R30 had to wait >20 minutes on 10 occasions and >30 minutes on three occasions. R102's diagnoses on the care plan dated 6/27/14, included cerebral vascular accident and diabetes mellitus. R102's MDS dated 10/3/14, identified R102 had intact cognition and required extensive assistance with ADL's. During an interview on 12/8/14, R102 and family member (F)-A indicated that sometimes it took a half hour for someone to answer the call light. Review of the call light response log for the past three months indicated R102 had to wait >20 minutes on 50 occasions and >30 minutes on 20 occasions. R125's diagnoses on the care plan dated 11/26/14, included disorder of the lumbar region and diabetes mellitus. R125's MDS dated 11/26/14, identified R125 had intact cognition and required assistance with ADL's. Review of the call light response log since R125's admission date of 11/26/14, indicated R125 waited for >20 minutes on one occasion. R33's diagnoses on the care plan dated 11/26/14, included cellulitis and abscess of leg. R33's MDS dated 11/6/14, identified R33 had moderate	F 353		

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F 353	Continued From page 35 cognitive impairment and required extensive assistance with ADL's. During an interview on 12/9/14, at 11:15 a.m. R33 reported that she never got to go to the bathroom when she wanted to and indicated she would wait for 15-30 minutes and had to hold it. Review of the call light response log for the past three months indicated R33 had to wait >20 minutes on 17 occasions and > 30 minutes on seven occasions. Review of the Restorative Nursing book revealed a communication note from OT dated 7/5/14, which directed staff to complete ROM exercises with R33 three times a week. Also in the book under R33's room number was directions for completing the ROM on both arms and legs. On 12/12/14, at 7:40 a.m. NA-H stated she had never done any ROM exercises with R33. She further stated she wasn't aware of any order for ROM and that she wouldn't have time to do ROM if she did know about it. NA-H commented that they were usually short of staff and didn't have time to do ROM. R17's diagnoses on the care plan dated 5/2/14, included chronic ischemic heart disease and generalized pain. R17's MDS dated 10/16/14, identified R17 was cognitively intact and required extensive assistance with ADL's. During an interview on 12/11/14, at 11:22 a.m. R17 reported that he has had to wait 30 minutes at times to use the bathroom. R17 further stated, "I sat here waiting for them to come and then I pooped my pants and had to sit in that for another 30 minutes to an hour." Review of the call light response log for the past three months indicated R17 waited for >20 minutes on 33 occasions and >30	F 353		

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F 353	Continued From page 36 minutes on eight occasions. R127's diagnoses on the care plan dated 11/28/14, included muscle weakness and hypertension. R127's MDS dated 11/28/14, identified that assistance with ADL's was required. During an interview on 12/9/14, at 1:19 p.m. R127 stated, "I have this call button and you're supposed to press it when you need something. I press it and it takes half an hour to an hour. When you have to go to urinate, and you can't hold it, you wet yourself. I've had lots of accidents." Review of the call light response log since R127 was admitted on 11/28/14, indicated that R127 waited for >20 minutes on two occasions. R126's diagnoses on the care plan dated 11/20/14, included cellulitis and abscess of foot. R126's MDS dated 11/20/14, identified R126 to have intact cognition and required extensive assist with ADL's. During an interview on 12/8/14, at 6:44 p.m. R126 indicated that, "They are understaffed here. I have to go to the pot every hour. I've had to wait forever." Review of the call light response log since R126 was admitted 11/20/14, indicated R126 waited for >20 minutes on four occasions and >30 minutes on two occasions. R11's diagnoses on the care plan dated 12/7/14, included diabetes mellitus and hypertension. R11's MDS dated 8/29/14, identified R11 to have moderate cognitive impairment and required	F 353		

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F 353	Continued From page 37 extensive assistance with ADL's. During interview on 12/9/14, at 11:31 a.m. R11 stated she felt the facility was short staffed and especially in the evenings. R11 shared the example of how one staff would come in and get her undressed and then she would have to sit and wait until someone else could get her into bed. R11 stated she had complained about there not being enough staff before but nothing had improved. Review of the call light response log for the past three months indicated that R11 waited for >20 minutes on 30 occasions and >30 minutes on five occasions. R45's diagnoses on the care plan dated 4/4/14, included encephalopathy and congestive heart failure. R45's MDS dated 9/4/14, identified R45's cognitive skills as consistent and reasonable and she required extensive assistance of two staff for ADL's. During an interview on 12/9/14, at 1:47 p.m. R45 indicated that the staff have told her they did not have enough staff and R45 agreed that there was not enough staff. Review of the call light response log for the last three months indicated that R45 waited for >20 minutes on 94 occasions and >30 minutes on 31 occasions. R66's diagnoses on the care plan dated 12/8/14, included joint replacement and generalized pain. R66's MDS dated 11/15/14, identified R66 to have intact cognition and required limited assist with ADL's. During an interview on 12/9/14, at 10:13 a.m. R66 indicated that she didn't feel there was enough staff and that sometimes she had to wait a half hour before anyone comes. Review of the call light response log for the past three	F 353		

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F 353	Continued From page 38 months indicated that R66 waited for > 20 minutes on 24 occasions and for > 30 minutes on seven occasions. R7's diagnoses on the care plan dated 12/12/14, included diabetes mellitus and hypertension. R7's MDS dated 11/9/14, identified R7 to have intact cognition and required limited assistance with ADL's. During an interview on 12/11/14, at 8:07 a.m. R7 stated, "The light will be on and the girls will walk by and shut it off. They all go on break together sometimes, usually in the afternoon. Sometimes I will have to wait a half hour or an hour." Review of the call light response log did not indicate that the call light was on for >20 minutes. R23's diagnoses on the care plan dated 9/3/14, included osteoarthrosis and anxiety state. R23's MDS dated 9/3/14, identified R23 to have intact cognition and required limited assistance with ADL's. During interview on 12/9/14, at 9:11 a.m. R23 stated she didn't like to complain, but the facility never seemed to have enough staff. R23 stated she sat on the toilet for a half an hour waiting for help because the staff were so tied up and said she recalled it so well because it was so uncomfortable to sit there for so long. R23 added that she tried to not be demanding because she knew the staff were pushed hard. Review of the call light response log for the past three months indicated that R23 waited for > 20 minutes on ten occasions and for > 30 minutes on five occasions.	F 353		

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F 353	Continued From page 39 R60's diagnoses on the care plan dated 10/10/14, included hypertension and atrial fibrillation. R60's MDS dated 10/10/14 identified R60 to have severe cognitive impairment and required limited assistance with ADL's. During interview on 12/9/14, at 11:14 a.m. R60 stated she thought the facility was short staffed because on bath nights, she had to wait sometimes a long time for staff to get to her to complete the bath. During a follow up interview on 12/11/14, at 9:34 a.m. R60 reported that it sometimes took a long time for staff to answer her light. "I see the staff running all over the place. It just seems they don't have enough staff." Review of the call light response log for the past three months indicated that R60 waited for > 20 minutes on three occasions and for > 30 minutes on one occasion. R38's family member (F)-B reported concerns of insufficient staffing within the facility. R38's diagnoses on the care plan dated 11/17/14, included neoplasm of the prostate and cerebrovascular disease. R38's MDS dated 10/2/14, identified R38 had severe cognitive impairment and required extensive assistance with ADL's. During an interview on 12/9/14, at 10:56 a.m. F-B indicated that she does not think there is enough staff. F-B stated the facility would call two or three times a week for her to come in because R38 would get up a lot. F-B believed the facility didn't have enough staff to take the time to walk R38 which would prevent him from getting up so much. F-B stated, "Why do they have to call me all the time?"	F 353		

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F 353	Continued From page 40 R42's family (F)-C reported concerns of insufficient staffing within the facility. R42's diagnoses on the care plan dated 12/12/14, included diabetes mellitus and chronic kidney disease. R42's MDS dated 11/20/14, identified R42 to have severe cognitive impairment and required extensive assistance of two staff with ADL's. During an interview on 12/8/14, at 6:46 p.m. F-C stated R42 has had to wait too long for staff assistance and has soiled his pants while waiting. R4's quarterly MDS dated 8/23/14, indicated R4 was severely cognitively impaired and had no current functional losses of range of motion in the upper or lower extremities. Review of the Restorative Nursing book revealed a communication note from OT dated 8/7/14, which instructed staff to provide upper body ROM three times a week. Also in the book under R4's room number was directions for completing the ROM on both arms. R4's medical record lacked documentation by the licensed nursing staff which indicated ROM was being monitored and completed consistently. During interview on 12/12/14, at 7:32 a.m. NA-B was providing morning cares to R4. NA-B stated although she only had been employed by the facility for a short time, she knew ROM services were not always being done and were only completed when the staff had time.	F 353		

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F 353	Continued From page 41 Employee interviews also supported insufficient staffing concerns within the facility. During an interview on 12/10/14, at 6:52 a.m. nursing assistant (NA)-J reported that they are short on days and that it was stressful. NA-J stated, "We lost a lot of staff, some are getting better jobs." During interview on 12/10/14, at 7:00 a.m. licensed practical nurse (LPN)-A stated they should have three NAs to get the residents on the north wing up in the morning, but at the present time they were only provided two. LPN-A stated the NAs were pushed to their limit and with only two NAs, it was very difficult to get ROM and things completed. During an interview on 12/10/14, at 7:19 a.m. registered nurse RN-G reported that on nights they were short for one to three hours until days came in at 6:00 a.m. RN-E stated, "Sometimes residents wait too long for staff to answer lights. Care could be better." During an interview on 12/10/14, at 8:36 a.m. RN-E reported more staff lately was needed that many staff had quit. RN-E stated, "Documentation was not always being done." During follow up interview with NA-F on 12/10/14, at 1:51 p.m., she stated ROM didn't get done on a consistent basis because of the lack of staff	F 353		

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F 353	Continued From page 42 and time constraints. NA-F further stated that she felt ROM, "Was definitely on the back burner." During an interview on 12/10/14, at 8:52 a.m. NA-C stated, residents were not getting the attention they needed and minimum cares were being completed as a result of the short staffing. NA-C stated, "Face, hand and pericare didn't always get done as often as it should." During an interview on 12/10/14, at 11:52 a.m. NA-A reported they were short the last weekend and stated, she was worried because residents were not getting the care they needed. NA-A reported that the residents were not getting toileted as often as they should, especially if they required a mechanical lift. NA-A also stated, "To be honest, range of motion is not getting done". During an interview on 12/10/14, at 2:00 p.m. NA-F reported that she had only worked one or two day shifts with full staff since 9/14. NA-F reported that R33 had been in tears waiting to go to the bathroom and has had to wait. During an interview on 12/10/14, at 11:44 a.m. the administrator verified that staffing was a concern and reported that staffing on the day shift had been challenging.	F 353		

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F 353	Continued From page 43 During interview on 12/11/14, at 11:34 a.m. NA-G recalled residents having incontinent episodes because they had to wait for too long to get to the bathroom as there was not enough staff to get to everyone timely. NA-G stated, "It makes you feel like crap when you can't get to them sooner." In addition NA-G indicated on the weekends some residents didn't get to eat breakfast until 10:45 a.m. because there is not enough staff to get them up timely and then lunch is served at 11:30 a.m. During interview on 12/12/14, at 7:32 a.m. NA-B was providing morning cares to R4. NA-B stated although she only had been employed by the facility for a short time, she knew ROM services were not always being done and were only completed when the staff had time. During interview on 12/12/14, at 8:02 a.m. RN-E stated ROM and ambulation was not being provided to residents because of a lack of time and that staffing was an ongoing problem. During interview on 12/12/14, at 8:18 a.m. RN-C stated she had mentioned to the director of nursing that a restorative aid would be beneficial, but that the facility had enough challenges getting enough direct care staff, much less adding restorative staff too. RN-C, with tears in her eyes stated, people go through orientation and then they leave, "It's hard."	F 353		

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F 353	Continued From page 44 During interview on 12/12/14, at 9:20 a.m. NA-D stated he was working as a NA on the day shift and normally worked at a nearby facility. NA-D stated he had never been in this facility prior to 6:00 a.m. that morning and he had been recruited to fill the shift. During interview on 12/12/14, at 9:30 a.m. NA-E also confirmed working as a NA on the day shift, had also been recruited from a neighboring facility and had never worked at the facility prior to that day. Occupational health director (OHD)-A was interviewed on 12/12/14, at 9:47 a.m. OHD-A confirmed the facility currently had a shortage of staff and stated there were two NAs working the day shift who had never worked at the facility before today. OHD-A stated they were called in from a neighboring facility to work just for the day. In addition OHD-A confirmed she was working as a NA for part of the day shift that day. During an interview on 12/12/14, at 8:39 a.m. the director of nursing (DON) stated that, "The expectation is that the light should be answered within five minutes to a least check on the resident and let them know when they can get back and to verify that it is not an emergency." The DON verified that she was aware staff were prioritizing their care to get done what they felt was most important and that ROM, ambulation and restorative programs were not being completed as a result. The DON stated,"Wish they weren't prioritizing because all aspects of	F 353		

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F 353	Continued From page 45 care are important." During follow up interview on 12/12/14, at 10:50 a.m. the DON confirmed the facility had a staffing shortage and had been experiencing the shortage since 7/14. Review of the an addendum to resident council meeting minutes dated 11/24/14, revealed residents were concerned about the short staffing and that they need more staff. The minutes noted complaints from residents which included beds not being made for days at a time and NA's working too fast and leaving residents without ensuring all of their needs had been met. In addition the nurses were working on the floor as nursing assistants. The facility's Staffing policy revised 4/07, noted, "Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services." The policy added that NAs were to be available to meet the needs of each resident as outlined in their written plan of care. The staffing sheets during the period of 11/10/14-12/10/14 indicated that there were frequent partial and full open shifts with various staff working anywhere form one to four hours to fill them. Staffing sheets for Monday 11/10/14 and Thursday 11/20/14 indicated five unfilled NA positions for that 24 hour period. Staffing sheet for Tuesday, 11/11/14 indicated four unfilled NA positions for that 24 hour period. During an	F 353		

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F 353	Continued From page 46 interview on 12/10/14 at 6:52 a.m. NA-J indicated that a star system is used when people call in or they are short. Staff scheduled for a regular shift will either cover the 4 hours before it or the 4 hours after it in an effort to meet staffing needs.	F 353		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		

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F 431	Continued From page 47 be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently document the destruction of used Fentanyl (a narcotic pain medication) patches in a manner to prevent potential diversion according to the facility policy, for 2 of 2 residents (R24 and R45) who were prescribed a Fentanyl patch. Findings include: R24's physician orders dated 11/6/14, included a medication order for Fentanyl Patch 72 hour 25 microgram (mcg) per hour, to be applied transdermally (on the skin) every three days for generalized pain. R45's physician orders dated 12/7/14, included a medication order for Fentanyl Patch 72 hour 50 mcg per hour, to be applied transdermally every three days, for generalized pain. During medication storage review of the medication cart on the north wing, on 12/12/14, at 9:03 a.m., registered nurse (RN)-B revealed the facility's policy for removal and disposal of Fentanyl patches was for two licensed staff to fold the patch, wrap it in a tissue, and flush it down the sewer system, and then both staff sign to verify that it was removed from the resident, and destroyed. At 9:25 a.m., during medication storage review of the medication cart on the southeast wing, RN-A revealed the facility's policy and procedure for the removal and disposal of	F 431	F431 Medications will be destroyed per facility Fentanyl Patch, Narcotic Medication Destruction policy. R24 and R45 Fentanyl patches are destroyed per policy on an ongoing basis. Primary licensed staff were instructed on proper disposal techniques/requirements. Effective Date: staff will follow policy immediately. 12/12/2015 Systemic Prevention of recurrence: • Follow-up staff education of policy and practice expectation completed 1/12/205 • Training of proper medication disposal included on new licensed nurse employee competency schedule Monitoring: Monthly monitoring for three months of medication documentation to ensure compliance with Fentanyl Patch Narcotic medication policy Responsible Staff: Monitoring completed by Occupational Health and Learning Director or designee to ensure compliance is maintained.	

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F 431	Continued From page 48 Fentanyl patches were for two licensed staff to witness the disposal of the used Fentanyl patch down the sewer and for both staff to sign off on the "Disposal of Narcotic Medications by Nursing" form of the disposal. A review of the "Disposal of Narcotic Medications by Nursing" form for R24, revealed instructions that included, "For used patches wrap in toilet paper and flush all narcotics down the sewer." R24's form lacked dual witness signatures for destruction of the used Fentanyl patch for 9/10/14, 9/25/14, 11/3/14, 11/24/14, and 12/3/14, revealing only one signature. The form lacked evidence that the patch had been destroyed, on 11/6/14 and 11/18/14, with no signatures at all. A review of the "Return/Disposal of Medications" form for R45, lacked dual witness signatures for destruction of the used Fentanyl patch for 11/26/14 and 12/2/14, with only one signature, and lacked evidence that the patch had been destroyed, on 11/5/14, 11/8/14, and 11/29/14, with no signatures at all. During an interview on 12/12/14, at 10:30 a.m., RN-D stated, "Our policy indicates we should sign with two staff to destroy Fentanyl patches whenever removed." When RN-D reviewed the copies of R24 and R45's disposal sheets, she verified there were times when they had not been documented as destroyed, and when two nurses had not signed. RN-D stated, "The problem was two of our nurses are newer and I don't think they realized we had this policy..." During an interview on 12/12/14, at 10:40 a.m., RN-A revealed, "I just learned on Monday (12/8/14) that we were supposed to be	F 431		

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F 431	Continued From page 49 documenting and have a witness for each removal." During an interview on 12/12/14, at 10:46 a.m., director of nursing (DON) verified the missing documentation for R24 and R45. DON indicated the facility had newer nurses who were still learning. Review of the facility's Fentanyl Removal, Application and Destruction policy, dated 10/13, included, "27. Take the used patch to the locked medication room (without touching adhesive sides), complete Fentanyl destruction log or Medication Disposal Form, with two licensed nurses wrapping used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign the proper form for proof of destruction."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 50 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement proper infection control techniques for cleansing and storage of Foley catheter bags for 1 of 2 residents (R22) observed receiving catheter care and drainage bag changes. Findings Include: R22 had diagnoses which included: aftercare healing traumatic fracture; closed fx lumbar vertebra; acute respiratory failure; CHF; influenza A; hyperlipidemia; anemia; UTI; Esophageal reflux; hypothyroidism; hx of fall; chronic ischemic heart disease; generalized pain During observation on 12/08/14, at 6:08 p.m.	F 441	F441 Infection Control Policy regarding catheter care will be followed per facility routine. R22 catheter is discontinued. Prior to d/c resident catheter care was corrected by immediate individual and group staff education, providing correct supplies, and licensed staff monitoring. Systemic Prevention of recurrence: • Follow-up staff education of policy and practice expectation completed 1/12/2015 • NAR Competencies Updated 12/12/2014 Monitoring: Auditing of catheter care provided by staff will occur monthly for 3 months to ensure compliance with infection control policy. Responsible Staff: Monitoring completed by Director of Occupational Health and Learning or designee to ensure compliance is maintained.	

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F 441	Continued From page 51 R22's shared bathroom was observed to have a full size catheter bag containing an amber colored liquid sitting in a plastic basin, on the floor beside the toilet. The end of the catheter tubing which would connect to an indwelling catheter was observed with no cap on the end of the tubing, lying against the floor. This provided an open pathway from the end of the catheter tube into the drainage bag. During observation on 12/08/14, at 7:36 p.m. the basin with the full size Foley catheter bag and the tubing extending out of the basin onto the floor was still present. On 12/08/14, at 7:40 p.m. observation was made with RN-C in attendance who verified the full size Foley catheter bag with the connection tubing (uncovered end) were on the floor beside the toilet. The bag contained amber colored liquid and was inside a basin. The tubing extended out of the basin onto the floor tile. RN-C further verified that this was not in accordance with the facility policies. On 12/08/14, at 7:43 p.m. NA-G was interviewed and stated that the full size Foley catheter bag was R22's night catheter bag and that leaving it on the floor was not acceptable. NA-G then put on gloves and lifted the catheter bag which contained 75 milliliters of amber colored liquid which NA-I identified as urine. RN-C and NA-I verified the bag would have been changed to a leg bag when R22 got up on 12/08/14 at 7:00 a.m.. NA-G verified the bathroom was shared by three other residents. On 12/08/14, at 7:45 p.m. NA-I stated catheter bags should be emptied each shift. She further	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 52 stated the large catheter bag should have been cleansed with vinegar and put away in R22's room when it was changed to the leg bag on 12/08/14 at the time R22 got up for the day. She verified that R22 usually got up at 7:00 a.m. Observation on 12/09/14, at 8:10 a.m. indicated a plastic basin was observed sitting on the floor beside the toilet. The basin contained a catheter leg bag. RN-C entered the bathroom and verified that this was a leg bag for R22 who would have had the bag changed to a full sized catheter bag the night before when she was ready for bed. During an interview on 12/10/14, at 9:30 a.m. RN-C stated she expected the NAs to cleanse the catheter bag with vinegar at the time they were changed and then store them in the closet in the resident's room. RN-C indicated it was not accepted infection control practice to have a reusable catheter bag stored on the floor near a shared toilet. Review of the facility policy entitled Catheter Care last revised 10/10, revealed direction for the staff to ensure catheter tubing and drainage bag were kept off the floor, maintain a closed drainage system, and to empty the collection bag at least every eight hours. Additionally, the facility policy entitled, Disinfection of Urinary Drainage Bag (no date)directed staff to store the drainage bag after cleaning on a clean towel or in a clear plastic bag until next use.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/09/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH CARE CENTER	**201 OAKLAWN AVENUE MANKATO, MN 56001**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 09, 2014. At the time of this survey, Oaklawn Health Care Center was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code, Chapter 19 Existing Health Care Occupancies. Oaklawn Health Care Center was constructed in 1964 with one building addition constructed in 1995, is one-story and has a partial basement. It is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All resident rooms are protected with automatic, hard wired, interconnected smoke detectors. The facility has a capacity of 77 beds and had a census of 67 at time of the survey.	K 000		

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

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.