Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 6, 2026

Administrator
Oaklawn Care & Rehabilitation Center
201 OAKLAWN AVENUE
MANKATO, MN 56001

RE: CCN:245517
Cycle Start Date: June 10, 2026

Dear Administrator:

On June 10, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 10, 2026 (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).

In addition, if substantial compliance with the regulations is not verified by December 10, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 6, 2026

Administrator
Oaklawn Care & Rehabilitation Center
NO DATA

Re: State Nursing Home Licensing Orders
Event ID: 231A72-H1

Dear Administrator:

The above facility survey was completed on June 10, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division

Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH CARE, LLC	**201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
E0000	Initial Comments On 6/8/26-6/10/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		08/01/2026
F0000	INITIAL COMMENTS On 6/8/26-6/10/26, a standard recertification survey (S5517040) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: NO deficiencies were cited. H55172782C (3027665) H55172784C (2694063) H55179165C (2680563) H55172786C (2655682) H55172787C (1118337) H55172788C (1118431) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F0000		08/01/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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F0000	Continued from page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		08/01/2026
F0921 SS = F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe, sanitary and comfortable environment for 1 of 1 residents (R2) whose room was unkept and had resident care items placed on the floor. In addition, the facility failed to perform daily cleaning in the kitchen which had the potential to affect 54/56 residents who received food from the kitchen. Findings include: R2 R2's face sheet received on 6/10/26, included diagnoses of diabetes, dementia, and chronic gastritis (inflammation of stomach lining). R2's quarterly Minimum Data Set (MDS) assessment dated 3/25/26, indicated intact cognition, clear speech, could understand and be understood. R2 was able to eat independently and required substantial assistance or was dependent on staff for activities of daily living (ADLs). R2 did not walk. R2's physician orders dated 9/24/25, indicated to apply foot to calf wraps (black) at bedtime. Orders dated 3/23/26, indicated Ready Wraps firm and snug around foot, ankle, and calf in the morning. R2's care plan dated 3/11/26, indicated an alteration in mobility related to diagnoses and transferred with a mechanical lift with assist of two staff using a large sling. During an interview and observation on 6/8/26 at 12:06 p.m., R2 was sitting in her recliner. Observed a number of items on the carpeted floor at the foot	F0921	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. How corrective action will be accomplished for those residents found to have been affected by the deficient practice R2 – Resident room concerns identified during survey were immediately addressed, excess items were removed, and the room was reorganized to promote a safe, sanitary, comfortable, and home-like environment. Kitchen cleanliness concerns identified during survey were immediately addressed and cleaning completed. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur All residents residing in the facility have the potential to be affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur A full house audit of resident rooms was completed to identify additional concerns related to room organization, cleanliness, and storage of resident care items. Rooms requiring intervention were addressed immediately. Review of Personal Belongings Policy and education was provided to Housekeeping	08/01/2026

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F0921 SS = F	Continued from page 2 of her bed: mechanical lift sling, pillow without a pillowcase, blankets, heel boots. Behind the recliner was a piece of wood resembling a slider board, cloth tote bag, blanket. Along with a TV, the top of the built-in credenza was entirely covered with various items: R2's personal items such as stuffed animals, empty vases, candle, figurines, three pair of slipper socks, two denture cups and mail. In addition, facility supplies: two stacks of briefs, two packages of wipes, gait belt, partial package of 4 x 4 dressings, a spray bottle of wound cleanser and chux (absorbent disposable pads). R2 stated staff didn't have time to straighten up her room. During an observation and interview on 6/9/26 at 1:39 p.m., together with nursing assistants NA-A, NA-B, and the director of nursing (DON), entered R2's room to observe items on the floor and the clutter on the credenza. Informed of observation the morning prior with items on the floor. The items that had been on the floor were now heaped on R2's bed. The DON stated staff took items off R2's bed in the evening and put them in her recliner and in the morning, put them back on her bed. With regard to the credenza, the DON stated she expected nurses to put wound supplies away in cupboard and for NAs to put briefs and wipes away. The DON stated extra blankets should be put in her closet. The DON admitted the room lacked storage surfaces for things like heel boots and the sling. During an interview on 6/9/26 at 1:44 p.m., NA-B stated R2 liked lots of blankets because she was usually cold, adding there wasn't enough room for everything and admitted staff could do a better job putting away their supplies. NA-B stated the blankets that had been on the floor the day prior were sent to laundry. During an interview on 6/9/26 at 6:55 p.m., R2 stated she didn't like when staff put things on the floor and didn't like all of the items on the credenza, adding she didn't have the ability to clean up it up herself. R2 stated staff should put their things away. During an interview on 6/10/26 at 7:35 a.m., housekeeper (H)-A stated she cleaned R2's room, and frequently there were items on the floor. H-A acknowledged seeing blankets, pillow, sling and heel boots on the floor, "every day." If R2 was in bed, she put those things on her recliner and if she was in her recliner, put things on her bed -- adding there weren't enough places to store things. To clean under everything on the credenza, H-A stated she picked up one item at a time, wiped under it and set it back down. H-A stated briefs and wipes were	F0921	Continued from page 2 and Nursing staff regarding home-like environment expectations, room organization, and storage of resident care items. Review of Monarch's Cleaning and Disinfection Policy. Education was provided to culinary manager and staff regarding kitchen cleanliness, sanitation expectations, and completion of required cleaning assignments and checklists. New daily cleaning checklist has been created and implemented. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Housekeeping manager or designee will complete random audits of resident rooms to ensure compliance twice weekly x4 weeks, weekly x4 weeks, monthly x1 month, and will report to QAPI committee for further review and recommendations. Dietary manager or designee will complete random audits of kitchen cleanliness to ensure compliance twice weekly x4 weeks, weekly x4 weeks, monthly x1 month, and will report to QAPI committee for further review and recommendations.	08/01/2026

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F0921 SS = F	Continued from page 3 commonly on the credenza. During an interview and observation on 6/10/26 at 9:40 a.m., the credenza had about 50% less items/clutter on it. R2 stated it was much better, “I like it.” No medical supplies/briefs/wipes were on the credenza. Heel boots, pillow, etc., were on the bed. Facility Personal Belongings policy dated 5/2026, indicated residents were encouraged to personalize their rooms to create a home-like environment. Residents had the right to retain and use personal clothing and possessions as space permitted, provided they did not infringe on the health, safety, or rights of others. At times, a resident’s room may need to be cleaned or reorganized. KITCHEN During initial kitchen tour on 6/8/26 at 6:25 a.m., with cook (C)-A, observed a dusty 8-inch black fan blowing toward food prep area on center island (no food was being prepped at that time). Observed smudges/smears on upper and lower metal cabinet doors, microwave door, and dried liquid drippings down the side of metal cabinet next to the oven. Crumbs on ledge of oven door. Crumbs on the bottom shelf of metal transport cart, crumbs on shelving inside lower metal cabinets. Box fan sitting on top of a yellow rubber receptable on wheels, not turned on, but with grayish material on the blades. Observed the solid surface flooring with non-skid surface; original color appeared to be taupe, but many areas were gray/blackish. Crumbs and debris were on the floor prior to food prep starting for the day. C-A stated dietary staff cleaned the kitchen daily and did a deep clean twice a year. During an interview on 6/9/26 at 10:29 a.m. dietary director (DD)-E and regional culinary director (CD)-F, were informed of concerns with cleanliness in the kitchen. Initially DD-E stated the reason was nursing staff entering the kitchen after hours but admitted that wouldn’t account for crumbs inside cupboard shelves, and dirty stainless steel cupboard doors. CD-F stated the responsibility fell to him too; he was supposed to come monthly for a mock survey, but due to his workload, hadn’t been able to. DD-E stated there were daily cleaning duties assigned to the cook and dietary aide. Reviewed completed checklists from a folder in her office, titled Closing List for Culinary. One half of the checklist indicated duties for the dietary aide and the other half for the cook. Duties included sweeping, wiping down	F0921		08/01/2026

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F0921 SS = F	Continued from page 4 counters and microwave inside and out, mopping, wiping down all sliding cabinet doors. For June, checklists indicated duties were done on only 6/1/26, 6/3/26, and 6/8/26, and of those, only the aides completed their duties; the cook duties were not initialed as having been completed. DD-E stated if the form had not been completed, she would assume the duties had not been done. Completion of daily Closing List for Culinary: April - completed 15/30 days, May - completed 19/31 days, and June partially completed 3/8 days. During a telephone interview on 6/9/26 at 11:38 a.m., registered dietician (RD)-G was informed of findings related to cleanliness. RD-G stated she was more on the clinical nutrition side and CD-F did the kitchen audits. RD-G had not been aware CD-F had not been able to do the audits due to workload. RD-G was not aware the kitchen had a daily end of shift checklist to complete for the day and evening staff. RD-G stated she would discuss concerns with DD-E and CD-F. During an interview on 6/10/26 at 10:47 a.m., with administrator, DD-E and CD-F, informed of cleanliness findings. The administrator had not been aware and stated they would address it. Facility Cleaning and Disinfection policy dated 9/12, indicated countertops, work surfaces and hard surfaces were to be wiped of excess particle of food, sprayed with a disinfectant solution and re-washed and wiped dry. Facility Sanitization policy dated October 2008, indicated the food service area would be maintained in a clean and sanitary manner. All kitchen areas would be clean. All counters and shelves would be kept clean.	F0921		08/01/2026
F0809 SS = E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast	F0809	F809 – Plan of Correction (Revised) Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. 1. How corrective action was accomplished for the residents identified in the deficiency R2 and R42 were offered evening nutrient- and calorie-substantive snacks based on their	08/01/2026

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OAKLAWN HEALTH CARE, LLC	**201 OAKLAWN AVENUE , MANKATO, Minnesota, 56001**

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F0809 SS = E	Continued from page 5 the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure nutrient and/or calorie substantive snacks were offered after the evening meal and before bedtime, for 2 of 2 residents (R2, R42) when there had been more than a 14-hour lapse between the dinner meal and breakfast the following day. This had the potential to affect 54 of 56 residents who ate meals at the facility. Findings include: R2 R2's face sheet received on 6/10/26, included diagnoses of diabetes, dementia, and chronic gastritis. R2's quarterly Minimum Data Set (MDS) assessment dated 3/25/26, indicated intact cognition, clear speech, could understand and be understood. R2 was able to eat independently but required substantial assistance or was dependent on staff for activities of daily living (ADLs). R2 did not walk. R2's physician orders dated 1/20/26, included Con/CHO (controlled carbohydrate) 2-gram sodium diet, regular. R2's care plan dated 3/11/26, indicated potential for alteration in nutrition related to diagnoses. During an observation on 6/9/26 at 9:08 a.m., observed R2's breakfast tray delivered to her room. During an interview on 6/9/26 at 5:52 p.m., R2 who preferred to eat meals in her room, stated she went from supper and until breakfast the following day without food and got hungry. R2 stated she would like to eat breakfast earlier in the morning as her breakfast tray arrived late.	F0809	Continued from page 5 preferences and diet orders. Snack bins were stocked with approved substantial snack options to ensure snacks were available for residents who requested them. 2. How the facility identified other residents who had the potential to be affected All residents receiving meals from the facility were reviewed, as all residents had the potential to be affected by this practice. The facility ensured all residents were offered evening nutrient- and calorie-substantive snacks based on their diet orders and preferences. Snack bins were stocked on all units to ensure approved substantial snacks were available. 3. What measures or system changes were put into place to ensure the deficient practice will not recur The facility reviewed Monarch's Mealtime and Snack Cart policies and implemented an updated substantial bedtime snack process. Unit snack bins and the snack cart were updated with nutrient- and calorie-substantive snack options that meet residents' diet orders. The updated process includes additional substantial snack options, snack pass assignments, and improved documentation. Education was provided to culinary and nursing staff regarding Monarch's Mealtime and Snack Cart policies, the updated substantial snack process, and expectations. Dietary staff were educated on stocking and delivering snacks to each unit. Nursing staff were educated to offer bedtime snacks to all residents based on their diet orders and preferences and to document when snacks are offered. 4. How the facility will monitor its corrective actions to ensure the deficient practice is corrected and will not recur Culinary manager or designee will complete random audits to ensure compliance twice weekly x4 weeks, weekly x4 weeks, monthly x1 month, and will report to QAPI committee for further review and recommendations.	08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026

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F0809 SS = E	Continued from page 6 R42 R42's face sheet received on 6/10/26, included diagnoses of diabetes, duodenal ulcer, and chronic kidney disease. R42's quarterly MDS dated 5/15/26, indicated intact cognition, clear speech, could understand and be understood, and was independent with ADLs. R42's physician orders included consistent carbohydrate diet, regular texture. R42's care plan dated 5/20/26, indicated a potential for alteration in nutrition related to diagnoses. During an interview on 6/8/26 at 10:23 a.m., R42 stated he ate in his room, adding it was pretty typical to eat breakfast around 9:30 a.m. R42 stated he was rarely offered a snack after supper before bed and would like that sometimes. During an observation on 6/9/26 at 9:01 a.m., observed breakfast tray delivered R42's room. During an interview on 6/9/26 at 10:29 a.m., with dietary director (DD)-E and regional culinary director (CD)-F, reviewed a document titled Dietary Service Hours, which indicated the following mealtimes for each unit: BREAKFAST ends at 10:00 a.m. 7:30 a.m. dining room opens 7:45 a.m. west unit delivery 8:15 a.m. east unit delivery 8:45 a.m. north unit delivery LUNCH ends at 1:00 p.m. 11:30 a.m. dining room opens 11:45 a.m. west unit delivery 12:15 p.m. east unit delivery 12:30 p.m., north unit delivery SUPPER ends at 6:15 p.m.	F0809		08/01/2026

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F0809 SS = E	Continued from page 7 4:45 p.m. dining room opens 5:00 p.m. west unit delivery 5:30 p.m. east unit delivery 6:00 p.m. north unit delivery The dietary service hours indicated 14 hours and 45 minutes between supper one day and breakfast the next morning. DD-E admitted some residents complained about receiving breakfast trays to their room too late in the morning but were told they could come to the dining room for breakfast in order to be served sooner. DD-E stated dietary staff would accommodate resident requests to receive a room tray at a particular time. During an interview on 6/9/26 at 3:28 p.m., registered dietician (RD)-G was unaware of scheduled mealtimes, adding it was her understanding there should be no more than 14 hours between supper and breakfast the following day unless a nutritious snack was provided to residents. Informed the snacks available to residents at bedtimes included unsweetened apple sauce, zero sugar pudding, snack-size bags of pretzels and goldfish crackers, fig bars, cookies, and glazed buns. RD-G acknowledged those snacks wouldn't be considered nutritious. During an interview on 6/10/26 at 10:47 a.m., the administrator, DD-E and CD-F were informed of the concern of more than 14 hours between the supper meal and breakfast the next day without a nourishing snack. The Dietary Service Hours sign was given to the administrator for review. Informed there should be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime. The dietary manager acknowledged the snacks available to residents at bedtime would not be considered nourishing. The administrator was unaware and stated mealtimes would be addressed. Facility Mealtime policy dated 9/2012, indicated it was the policy to serve meals to meet the standards of the surveying agencies specifying no more than 14 hours between the evening meal one day and the breakfast meal of the next day.	F0809		08/01/2026

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F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure appropriate follow-up of urine culture and sensitivity results and failed to ensure antibiotic therapy was reviewed for effectiveness for 1 of 1 resident (R32) reviewed for antibiotic use. In addition, the facility failed to ensure a nutritious snack was offered for the management of low blood sugar and failed to inform the dietician of concerns with blood sugar levels for 1 of 1 resident (R50) reviewed for food. Findings include: Antibiotic Use R32’s significant change in status Minium Data Set (MDS) assessment dated 5/6/26, indicated moderately impaired cognition, utilized a wheelchair, required supervision or touching assistance with toileting hygiene and personal hygiene, diagnoses included bladder cancer, hydronephrosis (urine doesn’t fully empty from the body), and hematuria (blood in urine). R32’s care plan dated 5/5/26, indicated alteration in elimination d/t (due to) weakness and assist with 2 staff and transfers, bladder cancer and prostate cancer assist of 2 with toileting, monitor urine for increased blood or pain with urination, will continue to have follow up appt with urology as scheduled, provide assistance with peri-cares AM (morning), HS (bedtime) and PRN (as needed), monitor foley catheter output, change foley catheter per policy, foley catheter care per policy. R32's urinalysis microbiology results dated 6/1/26, indicated greater than 100,000 colony forming units per milliliter (CFU/mL) of gram-negative rods with identification and sensitivity pending (lab has confirmed the bacteria’s species in the urine and is	F0684	Please accept this Plan of Correction as the facility’s credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. How corrective action will be accomplished for those residents found to have been affected by the deficient practice R 32 – Urine culture was reviewed, updated the hospice provider, and received new orders for an appropriate antibiotic. R 50 - Ensuring that a substantial snack will be offered for the management of low blood sugar. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur All residents receiving antibiotics based on culture results have the potential to be affected. All diabetic residents have the potential to be affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur A full house audit was completed for all residents currently receiving antibiotic treatment t o ensure antibiotic therapy was appropriate and effective. Reviewed Monarch’s Antibiotic Stewardship Program Policy, implemented a new culture review process, and provided corrective action to nurse identified to have failed to ensure appropriate follow up of urine culture and sensitivity results. Education was provided to facility nurses regarding Monarch’s Antibiotic Ste	08/01/2026

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F0684 SS = D	Continued from page 9 still running tests to see which antibiotics will work against it). R32's medication administration record (MAR) dated 6/1/26-6/30/26, indicated: Start date 6/1/26, UA/UC (urinalysis/urine culture) one time only for possible UTI (urinary tract infection) Start date 6/4/26, Ciprofloxacin (antibiotic) give 500 mg (milligrams) by mouth two times a day related to hematuria, for 5 Days, and discontinued 6/8/26. Start date 6/8/26, Sulfamethoxazole-Trimethoprim (antibiotic) give 1 tablet by mouth two times a day for UTI (urinary tract infection) for 7 days R32's urine culture and sensitivity report dated 6/3/26, identified the organism as resistant (R) to ciprofloxacin. On 6/8/26 at 1:46 p.m., licensed practical nurse (LPN)-B stated urine culture results were typically reviewed by the facility nursing staff and the provider would be expected to be notified if an organism was resistant to the prescribed antibiotic. LPN-B stated nursing staff were expected to address culture results and communicate concerns to the provider. On 6/8/26 at 1:56 p.m., the director of nursing (DON) reviewed R32's urine culture results dated 6/3/26, and confirmed the organism was resistant to ciprofloxacin. The DON confirmed R32 was currently prescribed ciprofloxacin. The DON stated nursing staff were expected to review culture and sensitivity reports, verify the prescribed antibiotic was susceptible to the identified organism, and notify the provider when resistance was identified. The DON stated they would have expected the provider to be notified regarding the resistant organism prior to 6/8/26. The DON further stated nursing staff was expected to place the paper copy of resident's culture in her office mailbox or under her office door as the she was the infection prevention nurse to include on her surveillance of infections. On 6/8/26 at 2:05 p.m., registered nurse (RN)-E, hospice nurse, stated ciprofloxacin had been ordered for R32 on 6/3/26, to provide coverage until culture results were available and stated facility nursing staff would be expected to notify hospice or the provider when culture results demonstrated resistance.	F0684	Continued from page 9 wardship Program Policy and the updated culture results review process. Reviewed Monarch's Mealtime and Snack Cart policies and implemented an updated substantial snack process that includes additional snack options, snack pass assignments, and improved documentation. Education was provided to facility culinary and nursing staff regarding Monarch's Mealtime and Snack Cart policies, updated substantial snack process and expectations. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee will complete random audits of culture results for appropriate antibiotic orders and bedtime snack pass to ensure compliance twice weekly x4 weeks, weekly x4 weeks, monthly x1 month, and will report to QAPI committee for further review and recommendations.	08/01/2026

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F0684 SS = D	Continued from page 10 On 6/8/26 at 2:12 p.m., LPN-C stated facility staff were expected to contact the provider when culture results indicated the prescribed antibiotic did not cover the identified organism. LPN-C stated she recalled receiving the culture results, signed off that they were reviewed, and provided the results to the hospice nurse for follow-up but did not document provider notification or the specific culture findings. On 6/8/26 at 2:44 p.m., LPN-B stated staff would generally assume culture results had been addressed if the paper copy was signed, and stated there was no process ensuring follow-up occurred after review of the culture results. On 6/8/26 at 3:28 p.m., RN-F, hospice nurse, stated R32's urine culture results were forwarded to the provider but acknowledged there was a breakdown in communication regarding review of the sensitivity report between the provider, hospice nurse and the facility. RN-F stated when the order was received for R32's cipro antibiotic hospice had not clarified if the provider had reviewed the culture results before continuing the antibiotic. On 6/8/26 at 3:43 p.m., the DON stated culture and sensitivity results should be reviewed to ensure the prescribed antibiotic is effective against the identified organism and acknowledged R32 was not included on the facility's infection tracking log. On 6/9/26 at 3:22 p.m., R32 stated he felt fine and denied urinary symptoms. Facility Antibiotic Stewardship Program Policy dated 11/24, indicated The Infection Preventionist, (IP), or designee, will review all antibiotic orders to determine if treatment is appropriate. Treatment is not appropriate if: The organism is not susceptible to the antibiotic chosen. The organism is susceptible to a narrower spectrum antibiotic. Therapy was ordered for prolonged surgical prophylaxis. Therapy was started awaiting culture, but no organism was isolated after 72 hours The provider will be notified of the review findings	F0684		08/01/2026

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F0684 SS = D	Continued from page 11 and recommendations and a response will be documented in the resident's medical record. The Infection Preventionist, along with the Consultant Pharmacist, will monitor antibiotic use by utilizing a facility approved infection/antibiotic surveillance tracking form and thru monthly medication reviews. The information gathered will include: Resident name Unit and room number Date symptoms appeared name of antibiotic Start date of antibiotic Pathogen identified Site of infection Date of culture Stop date Total days of therapy Outcome Adverse events, if applicable. Management Of Low Blood Sugar R50’s face sheet dated 4/18/26, indicated diagnoses of infection of skin tissue, type two diabetes mellitus with foot ulcer, moderate protein-calorie malnutrition, abnormal weight loss, long term use of insulin. R50’s admission Minimum Data Set (MDS) assessment dated 5/4/26, indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, independent with eating, partial assistance with dressing. R50’s care plan printed 6/10/26, indicated potential for alteration in blood sugar related to diagnosis of diabetes. Resident will be free from hyper/hypo glycemic episodes. Monitor for signs of hyper/hypoglycemia, diet as ordered. R50’s physician’s orders dated 6/4/26, indicated	F0684		08/01/2026

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F0684 SS = D	Continued from page 12 orders for continuous blood glucose sensor, metformin, Mounjaro, Jardiance, and Lantus (diabetic medications), consistent carbohydrate diet, follow standard house orders for blood sugars, monitor for signs of hyper/hypoglycemia, blood sugars before meals and at bedtime. During interview on 6/9/26 at 3:03 P.M., R50 stated he was happy with the care he received at the facility, but worried about his blood sugars. R50 stated supper was served at 4:45 p.m., and that was too early for him to eat to sustain his blood sugar through the night. R50 further stated that sometime he didn't get breakfast until 9:00 a.m., and his blood sugar would be lower throughout the night and in the morning. R50 stated he was not offered a substantial evening snack to help keep his blood sugar up through the night, but he had his daughter bring some snacks in for him to have in his room. R50 stated he did not like the feeling of low blood sugar and it worried him when it happened. R50 stated a blood sugar reading in the 90's or lower made him worry he was going to drop even more throughout the night and before breakfast without a substantial snack. Review of R50's blood sugar readings from 5/31/26 through 6/9/26, indicated the following readings he was not comfortable with: 5/31/26 at 9:10 a.m.: 87 6/4/26 at 10:10 p.m.: 88 6/5/26 at 8:02 a.m.: 86 6/8/26 at 7:06 a.m.: 65 6/9/26 at 7:33 p.m.: 86 During interview on 6/8/26 at 3:20 p.m., registered nurse (RN)-B stated there was an evening snack cart but there was nothing designated specifically for diabetic residents and nothing to indicate who should be offered a snack in the evening. RN-B further stated there were mostly carbohydrate snacks on the cart, no order for a substantial evening snack for diabetic residents, but that R50 could ask for something if he wanted a snack. On 6/8/26, the snack cart included unsweetened applesauce, zero sugar pudding, pretzels, goldfish crackers, fig bars, cookies, and honey buns. During interview on 6/9/26 at 3:03 p.m., RN-G stated there were no specific orders for a substantial	F0684		08/01/2026

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F0684 SS = D	Continued from page 13 evening snack for diabetic residents, but a snack cart was put out each evening. RN-G stated nothing was offered specifically to diabetic residents to ensure their blood sugar did not drop overnight or prior to breakfast. During interview on 6/9/26 at 3:23 p.m., director of nursing (DON) stated she was aware R50's blood sugar had been dropping consistently overnight and the provider had been notified to make medication changes, but had not considered providing an evening snack and had not contacted the dietician. DON stated providing diabetic snacks was not something they did, they just had a snack cart available for all residents. DON stated there was nothing labeled on the snack cart for diabetic residents to ensure they were offered a snack. DON stated she would have to add that order for diabetic residents to help maintain blood sugar overnight. During interview on 6/9/26 at 3:30 p.m., registered dietician (RD) stated she was newer to the facility and was not sure what was offered on the snack cart. RD stated she would expect snacks offered to diabetic residents after supper and they should include a carbohydrate and protein source. RD stated she would expect to be notified if a resident was having difficulty with blood sugar management so she could provide an order for a diabetic snack at night. RD stated she had not been made aware of any concerns with R50's blood sugar levels. Facility Snack Carts policy dated 9/2012, indicated facility policy to provide a nourishing snack daily. The hospitality staff will set up the cart and each cart will include these items: snacks, bars, cookies, fruit, crackers, sandwiches, beverages. These carts will be brought around to the resident's rooms by the nursing assistants.	F0684		08/01/2026
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to	F0688	F688 Plan of Correction (POC) (Revised) Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. How corrective action will be accomplished for those residents found to have been affected by the deficient practice	08/01/2026

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F0688 SS = D	Continued from page 14 increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to assess and implement interventions to maintain and/or prevent loss of range of motion (ROM) for 1 of 1 resident (R21) reviewed for ROM. Findings include: R21's quarterly Minimum Data Set (MDS) assessment dated 2/26/26, indicated moderately impaired cognition, no rejection of care, utilized a wheelchair, independent with eating, setup or clean-up assistance with oral hygiene, dependent with toileting hygiene, sit to lying, chair to bed transfer, toilet transfer, lower body dressing, substantial/maximal assistance with shower/bathe self, roll left and right, upper body dressing, and partial moderate assistance with personal hygiene; limitation range of motion on both sides of lower extremity and no impairment on upper extremity; diagnoses included non-Alzheimer's dementia, depression, Parkinsonism and not receiving a restorative nursing program.R21's quarterly MDS assessment dated 5/22/26, indicated moderately impaired cognition, no rejection of care, utilized a wheelchair, with eating, setup or clean-up assistance with eating, dependent with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, sit to lying, chair to bed transfer, toilet transfer; limitation range of motion on both sides of lower extremity and no impairment on upper extremity; diagnoses included non-Alzheimer's dementia, depression, Parkinsonism and not receiving a restorative nursing program. R21's care plan dated 5/22/26, indicated Parkinsonism, age-related physical debility, pain, osteoarthritis, history of falling, and weakness and interventions included PT (physical therapy) per MD (medical doctor)order, follow PT instructions, A (assist) x2 using mechanical lift for transfers, assist with movement in bed and in/out of bed, OT (occupational therapy) per MD order, follow OT instructions, assist with bathing with assist of 1 staff, assist with dressing with assist of 1 staff,	F0688	Continued from page 14 R 21 – She Was evaluated by therapy, and a Range of Motion "ROM" program was implemented. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur All residents with limited mobility had the potential to be affected. The facility reviewed residents identified through Census and Condition reports, including residents with limited range of motion, contractures, declines in ADLs, or declines in walking. Residents identified through the review were referred to the Therapy Director for follow-up, and interventions were implemented as appropriate. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur The facility reviewed Monarch's Activities of Daily Living/Maintain Abilities Policy and implemented an updated process to identify residents who may need interventions to prevent loss of range of motion. Nursing staff were educated to complete a "Hey Therapy" form for residents with changes in ADLs, mobility, or range of motion so therapy can evaluate and implement recommendations as appropriate. Residents with changes in ADLs, mobility, restorative needs, or range of motion are also reviewed during weekly Medicare meetings. Education was provided to therapy and nursing staff regarding Monarch's Activities of Daily Living/Maintain Abilities Policy, the updated process, and facility expectations. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee with complete random audits to ensure compliance weekly x4 weeks, monthly x2 months, and will report to QAPI committee for further review and recommendations.	08/01/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH CARE, LLC	201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0688 SS = D	Continued from page 15 assist with personal hygiene with assist of 1 staff. R21's document review failed to indicate documentation of interventions to maintain or prevent loss of ROM or strength of lower extremities. On 6/8/26 at 7:13 a.m., R21 stated, "I've asked about a stationary bike and weights, but get brushed off. I would like to keep my flexibility." R21 stated they do not walk, received no exercise to their joints, and expressed concern about losing her ability to move her joints freely. On 6/8/26 at 2:24 p.m., R21 was observed lying in bed and stated the facility did not provide exercises for the upper or lower body to maintain strength and stated they would participate if exercises were offered. On 6/8/26 at 2:28 p.m., nursing assistant (NA)-A, NA-B, NA-C stated exercise and restorative interventions would be documented in the electronic medical record (EMR) if in place. The nursing assistants reviewed the EMR and therapy communication book and confirmed there were no orders, tasks, or documentation indicating exercises, range of motion interventions, or restorative services for R21. NA-A, NA-B, NA-C further confirmed R21 required a mechanical lift and assistance of two staff for transfers. On 6/8/26 at 2:31 p.m., registered nurse (RN)-A, known as nurse manager, and licensed practical nurse (LPN)-A, known as a care coordinator, stated R21 was not on restorative program. RN-A stated therapy will pick residents up for for services if there is a specific need but services may be discontinued once a resident plateaus and confirmed there was nothing specific in place for R21 to maintain their strength. On 6/8/26 at 3:50 p.m., LPN-A stated if a resident had a decline in ADLs (activities of daily living) the decline would typically be discussed during routine Medicare meetings and therapy referrals would be considered if a decline was identified. When asked what interventions were currently being implemented to prevent decline, LPN-A stated she would need to look into it and noted that long-term care residents generally decline over time. RN-A stated the facility practice was for therapy to evaluate residents once a decline was observed. On 6/9/26 at 11:13 a.m., RN-B stated R21 required a wheelchair, assistance of two staff, and a mechanical lift for transfers, and further stated R21 was not	F0688		08/01/2026

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F0688 SS = D	Continued from page 16 receiving therapy services, had no range of motion program, and had no interventions in place to maintain strength. On 6/9/26 at 11:14 a.m., RN-C stated therapy would write any orders related to exercises or ROM programs if staff were expected to complete ROM with a resident and confirmed there were no ROM interventions for R21. On 6/9/26 at 11:15 a.m., NA-B stated R21 currently had nothing in place to maintain their strength such as ROM or exercises. On 6/9/26 at 11:16 a.m., RN-A and LPN-A stated they were unsure whether an order was required for ROM interventions and stated residents were typically referred to therapy after a decline was identified and confirmed there was currently nothing in place to prevent decline for R21. On 6/9/26 at 11:24 a.m., R21 was observed in bed and stated she was not offered exercises but would participate if they were available. R21 stated exercises would be nice to keep her strength up. R21 stated there were weights under my clothes across the room and stated she could not reach them. Two hand weights were observed across the room from R21's bed and found underneath clothing. R21 stated she would use the weights if they were placed within reach. R21's fingers on the right hand were curled inward toward the palm, the resident could open and close both hands, wiggle toes, but was unable to raise either leg from the bed. On 6/9/26 at 11:32 a.m., RN-A confirmed R21 had weights and exercise bands in their room, but was unsure where they had originated and if R21 was supposed to use them. On 6/9/26 at 11:34 a.m., the director of nursing (DON) stated residents were expected and should be encouraged to do as much as possible independently. DON stated therapy typically provided ROM exercises if a resident was expected to complete exercises and staff should report changes in condition to therapy. The DON further stated staff were expected to address declines and not simply capture them through MDS documentation. The DON stated exercises were important to keep the strength a resident has and maintain the strength. The DON stated if R21 had ROM limitations, would expect nursing to alert therapy to ensure interventions were in place for R21.	F0688		08/01/2026

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F0688 SS = D	Continued from page 17 On 6/9/26 at 1:38 p.m., the director of rehabilitation (DOR) stated they reviewed R21's information and stated therapy would typically provide recommendations for upper- or lower-extremity exercises as needed. DOR stated it was beneficial for residents to have a restorative nursing program to maintain current abilities and indicated that interventions to help prevent decline would have been warranted for R21. On 6/10/26 at 9:03 a.m., OT (occupational therapist)-A Meyer stated the facility had a transition of therapy companies and was unable to find documentation on whether R21 previously had exercise orders; however, OT-A stated they would have expected interventions to be in place due to R21's decreased lower-extremity function and limited range of motion. OT-A stated R21 had not walked for a long time and would expect PT (physical therapy) recommendations for lower-extremity exercises and reported PT had been asked yesterday to reassess the resident for possible restorative programming. On 6/10/26 at 10:00 a.m., RN-D, known as regional nurse consultant, stated the facility could not locate a previous physical therapy discharge recommendation, and further stated with the transition to a new PT provider the documentation was not readily available. RN-D stated R21 was evaluated by PT yesterday (6/9/26). The Facility Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: a. Hygiene –bathing, dressing, grooming, and oral care, b. Mobility—transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional	F0688		08/01/2026

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F0688 SS = D	Continued from page 18 communication systems. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.	F0688		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/09/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaklawn Care & Rehabilitation Center	**201 OAKLAWN AVENUE , MANKATO, Minnesota, 56001**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/09/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Oaklawn Care & Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		08/01/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/09/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Oaklawn Care & Rehabilitation Center is a one-story with partial basement facility was constructed in 1964, with one building addition constructed in 1995. The facility is fully sprinklered and was determined to be of Type II (111) construction. The facility has a capacity of 60 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		08/01/2026
K0347 SS = F Bldg. 01	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces	K0347	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567.	08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/09/2026**

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K0347 SS = F Bldg. 01	Continued from page 2 open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, the facility failed to inspect and test smoke alarms per NFPA 101 (2012 edition), Life Safety Code Section 9.6.2.10.1.1 or NFPA 99 (2012 edition), Health Care Facilities Code, section 15.7.3.1, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code Sections 14.2.1.1.2, 14.4.5, and 14.4.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/09/2026 at 9:49 AM, it was revealed by a review of available documentation that the facility was not inspecting and testing battery-operated smoke alarms monthly. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0347	Continued from page 2 CITED CONDITION: Ensuring smoke alarm inspections are done IMMEDIATE CORRECTIVE ACTION: The facility immediately completed the inspection and testing of all battery-operated smoke alarms throughout the facility to verify proper operation. Any identified concerns were corrected immediately. LIKE SYSTEMS: The facility reviewed all battery-operated smoke alarms throughout the building to ensure that each alarm was identified and included on the monthly inspection and testing schedule. PREVENT RECURRENCE: Education was provided to the Maintenance Director regarding the process for scheduling and tracking required monthly smoke alarm inspections in Monarch's TELS electronic system to ensure inspections are completed timely. MONITORING: The Maintenance Director or designee will complete audits of battery-operated smoke alarm inspection documentation monthly for three months. Audit results will be reviewed by the Administrator and reported to the QAPI Committee for review and evaluation. The QAPI Committee will determine the need for continued monitoring or additional corrective actions based on the audit results.	08/01/2026
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with	K0324	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567.	08/01/2026

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K0324 SS = E Bldg. 01	Continued from page 3 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection records and safety measures associated with cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.2.3. and NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations section 11.3.3 and 11.6.10. This deficient practice could have a patterned impact on the residents within the facility. Findings include: On 06/09/2026 at 10:43 AM, it was revealed by observation and staff interview that the facilities kitchen fire suppression did not have an inspection tag. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0324	Continued from page 3 CITED CONDITION: Ensuring that the fire suppression system have inspection tag on. IMMEDIATE CORRECTIVE ACTION: The facility immediately reviewed the kitchen fire suppression system inspection. The vendor was contacted to provide facility with inspection tag. LIKE SYSTEMS: The facility reviewed all fire suppression systems throughout the facility to ensure that all required inspections had been completed and that current inspection documentation and tags were in place. PREVENT RECURRENCE: Education was provided to the Maintenance Director regarding the process for verifying that inspection tags are received and maintained following vendor inspections. The vendor will provide the facility with the required inspection tags for the fire suppression system. MONITORING: The Maintenance Director or designee will audit fire suppression system inspection documentation monthly for two months to ensure required inspections are completed and current inspection tags are maintained. Audit results will be reviewed by the Administrator and reported to the QAPI Committee for review and determination of the need for continued monitoring or additional corrective action.	08/01/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/8/26 -6/10/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: NO licensing orders were issued.	20000		08/01/2026

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20000	Continued from page 1 H55172782C (3027665) H55172784C (2694063) H55179165C (2680563) H55172786C (2655682) H55172787C (1118337) H55172788C (1118431) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		08/01/2026

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20890	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2 A Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to assess and implement interventions to maintain and/or prevent loss of range of motion (ROM) for 1 of 1 resident (R21) reviewed for ROM. Findings include: R21’s quarterly Minimum Data Set (MDS) assessment dated 2/26/26, indicated moderately impaired cognition, no rejection of care, utilized a wheelchair, independent with eating, setup or clean-up assistance with oral hygiene, dependent with toileting hygiene, sit to lying, chair to bed transfer, toilet transfer, lower body dressing, substantial/maximal assistance with shower/bathe self, roll left and right, upper body dressing, and partial moderate assistance with personal hygiene; limitation range of motion on both sides of lower extremity and no impairment on upper extremity; diagnoses included non-Alzheimer’s dementia, depression, Parkinsonism and not receiving a restorative nursing program.R21’s quarterly MDS assessment dated 5/22/26, indicated moderately impaired cognition, no rejection of care, utilized a wheelchair, with eating, setup or clean-up assistance with eating, dependent with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, sit to lying, chair to bed transfer, toilet transfer; limitation range of motion on both sides of lower extremity and no impairment on upper extremity; diagnoses included non-Alzheimer’s dementia, depression, Parkinsonism and not receiving a restorative nursing program.	20890	CORRECTED	08/01/2026

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20890	Continued from page 3 R21's care plan dated 5/22/26, indicated Parkinsonism, age-related physical debility, pain, osteoarthritis, history of falling, and weakness and interventions included PT (physical therapy) per MD (medical doctor)order, follow PT instructions, A (assist) x2 using mechanical lift for transfers, assist with movement in bed and in/out of bed, OT (occupational therapy) per MD order, follow OT instructions, assist with bathing with assist of 1 staff, assist with dressing with assist of 1 staff, assist with personal hygiene with assist of 1 staff. R21's document review failed to indicate documentation of interventions to maintain or prevent loss of ROM or strength of lower extremities. On 6/8/26 at 7:13 a.m., R21 stated, "I've asked about a stationary bike and weights, but get brushed off. I would like to keep my flexibility." R21 stated they do not walk, received no exercise to their joints, and expressed concern about losing her ability to move her joints freely. On 6/8/26 at 2:24 p.m., R21 was observed lying in bed and stated the facility did not provide exercises for the upper or lower body to maintain strength and stated they would participate if exercises were offered. On 6/8/26 at 2:28 p.m., nursing assistant (NA)-A, NA-B, NA-C stated exercise and restorative interventions would be documented in the electronic medical record (EMR) if in place. The nursing assistants reviewed the EMR and therapy communication book and confirmed there were no orders, tasks, or documentation indicating exercises, range of motion interventions, or restorative services for R21. NA-A, NA-B, NA-C further confirmed R21 required a mechanical lift and assistance of two staff for transfers. On 6/8/26 at 2:31 p.m., registered nurse (RN)-A, known as nurse manager, and licensed practical nurse (LPN)-A, known as a care coordinator, stated R21 was not on restorative program. RN-A stated therapy will pick residents up for for services if there is a specific need but services may be discontinued once a resident plateaus and confirmed there was nothing specific in place for R21 to maintain their strength. On 6/8/26 at 3:50 p.m., LPN-A stated if a resident had a decline in ADLs (activities of daily living) the decline would typically be discussed during routine Medicare meetings and therapy referrals would be	20890		08/01/2026

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20890	Continued from page 4 considered if a decline was identified. When asked what interventions were currently being implemented to prevent decline, LPN-A stated she would need to look into it and noted that long-term care residents generally decline over time. RN-A stated the facility practice was for therapy to evaluate residents once a decline was observed. On 6/9/26 at 11:13 a.m., RN-B stated R21 required a wheelchair, assistance of two staff, and a mechanical lift for transfers, and further stated R21 was not receiving therapy services, had no range of motion program, and had no interventions in place to maintain strength. On 6/9/26 at 11:14 a.m., RN-C stated therapy would write any orders related to exercises or ROM programs if staff were expected to complete ROM with a resident and confirmed there were no ROM interventions for R21. On 6/9/26 at 11:15 a.m., NA-B stated R21 currently had nothing in place to maintain their strength such as ROM or exercises. On 6/9/26 at 11:16 a.m., RN-A and LPN-A stated they were unsure whether an order was required for ROM interventions and stated residents were typically referred to therapy after a decline was identified and confirmed there was currently nothing in place to prevent decline for R21. On 6/9/26 at 11:24 a.m., R21 was observed in bed and stated she was not offered exercises but would participate if they were available. R21 stated exercises would be nice to keep her strength up. R21 stated there were weights under my clothes across the room and stated she could not reach them. Two hand weights were observed across the room from R21's bed and found underneath clothing. R21 stated she would use the weights if they were placed within reach. R21's fingers on the right hand were curled inward toward the palm, the resident could open and close both hands, wiggle toes, but was unable to raise either leg from the bed. On 6/9/26 at 11:32 a.m., RN-A confirmed R21 had weights and exercise bands in their room, but was unsure where they had originated and if R21 was supposed to use them. On 6/9/26 at 11:34 a.m., the director of nursing (DON) stated residents were expected and should be encouraged to do as much as possible independently. DON stated therapy typically provided	20890		08/01/2026

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20890	Continued from page 5 ROM exercises if a resident was expected to complete exercises and staff should report changes in condition to therapy. The DON further stated staff were expected to address declines and not simply capture them through MDS documentation. The DON stated exercises were important to keep the strength a resident has and maintain the strength. The DON stated if R21 had ROM limitations, would expect nursing to alert therapy to ensure interventions were in place for R21. On 6/9/26 at 1:38 p.m., the director of rehabilitation (DOR) stated they reviewed R21's information and stated therapy would typically provide recommendations for upper- or lower-extremity exercises as needed. DOR stated it was beneficial for residents to have a restorative nursing program to maintain current abilities and indicated that interventions to help prevent decline would have been warranted for R21. On 6/10/26 at 9:03 a.m., OT (occupational therapist)-A Meyer stated the facility had a transition of therapy companies and was unable to find documentation on whether R21 previously had exercise orders; however, OT-A stated they would have expected interventions to be in place due to R21's decreased lower-extremity function and limited range of motion. OT-A stated R21 had not walked for a long time and would expect PT (physical therapy) recommendations for lower-extremity exercises and reported PT had been asked yesterday to reassess the resident for possible restorative programming. On 6/10/26 at 10:00 a.m., RN-D, known as regional nurse consultant, stated the facility could not locate a previous physical therapy discharge recommendation, and further stated with the transition to a new PT provider the documentation was not readily available. RN-D stated R21 was evaluated by PT yesterday (6/9/26). The Facility Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the	20890		08/01/2026

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20890	Continued from page 6 appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: a. Hygiene –bathing, dressing, grooming, and oral care, b. Mobility—transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable polices and procedures pertaining to the timely completion of resident activities of daily living (ADLs); then inservice direct care staff on such procedures and audit to ensure ongoing compliance. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20890		08/01/2026
21030	Frequency of Meals; Time of meals CFR(s): MN Rule 4658.0620 Subp. 1 Subpart 1. Time of meals. The nursing home must provide at least three meals daily at regular times. There must be no more than 14 hours between a substantial evening meal and breakfast the following day. A "substantial evening meal" means an offering of three or more menu items at one time, one of which is a high-quality protein such as meat, fish, eggs, or cheese. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure nutrient and/or calorie substantive snacks were offered after the evening meal and before bedtime, for 2 of 2	21030	CORRECTED	08/01/2026

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21030	Continued from page 7 residents (R2, R42) when there had been more than a 14-hour lapse between the dinner meal and breakfast the following day. This had the potential to affect 54 of 56 residents who ate meals at the facility. Findings include: R2 R2's face sheet received on 6/10/26, included diagnoses of diabetes, dementia, and chronic gastritis. R2's quarterly Minimum Data Set (MDS) assessment dated 3/25/26, indicated intact cognition, clear speech, could understand and be understood. R2 was able to eat independently but required substantial assistance or was dependent on staff for activities of daily living (ADLs). R2 did not walk. R2's physician orders dated 1/20/26, included Con/CHO (controlled carbohydrate) 2-gram sodium diet, regular. R2's care plan dated 3/11/26, indicated potential for alteration in nutrition related to diagnoses. During an observation on 6/9/26 at 9:08 a.m., observed R2's breakfast tray delivered to her room. During an interview on 6/9/26 at 5:52 p.m., R2 who preferred to eat meals in her room, stated she went from supper and until breakfast the following day without food and got hungry. R2 stated she would like to eat breakfast earlier in the morning as her breakfast tray arrived late. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. R42 R42's face sheet received on 6/10/26, included diagnoses of diabetes, duodenal ulcer, and chronic kidney disease. R42's quarterly MDS dated 5/15/26, indicated intact cognition, clear speech, could understand and be understood, and was independent with ADLs. R42's physician orders included consistent carbohydrate diet, regular texture. R42's care plan dated 5/20/26, indicated a potential for alteration in nutrition related to diagnoses.	21030		08/01/2026

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21030	Continued from page 8 During an interview on 6/8/26 at 10:23 a.m., R42 stated he ate in his room, adding it was pretty typical to eat breakfast around 9:30 a.m. R42 stated he was rarely offered a snack after supper before bed and would like that sometimes. During an observation on 6/9/26 at 9:01 a.m., observed breakfast tray delivered R42's room. During an interview on 6/9/26 at 10:29 a.m., with dietary director (DD)-E and regional culinary director (CD)-F, reviewed a document titled Dietary Service Hours, which indicated the following mealtimes for each unit: BREAKFAST ends at 10:00 a.m. 7:30 a.m. dining room opens 7:45 a.m. west unit delivery 8:15 a.m. east unit delivery 8:45 a.m. north unit delivery LUNCH ends at 1:00 p.m. 11:30 a.m. dining room opens 11:45 a.m. west unit delivery 12:15 p.m. east unit delivery 12:30 p.m., north unit delivery SUPPER ends at 6:15 p.m. 4:45 p.m. dining room opens 5:00 p.m. west unit delivery 5:30 p.m. east unit delivery 6:00 p.m. north unit delivery The dietary service hours indicated 14 hours and 45 minutes between supper one day and breakfast the next morning. DD-E admitted some residents complained about receiving breakfast trays to their room too late in the morning but were told they could come to the dining room for breakfast in order to be served sooner. DD-E stated dietary staff would	21030		08/01/2026

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21030	Continued from page 9 accommodate resident requests to receive a room tray at a particular time. During an interview on 6/9/26 at 3:28 p.m., registered dietician (RD)-G was unaware of scheduled mealtimes, adding it was her understanding there should be no more than 14 hours between supper and breakfast the following day unless a nutritious snack was provided to residents. Informed the snacks available to residents at bedtimes included unsweetened apple sauce, zero sugar pudding, snack-size bags of pretzels and goldfish crackers, fig bars, cookies, and glazed buns. RD-G acknowledged those snacks wouldn't be considered nutritious. During an interview on 6/10/26 at 10:47 a.m., the administrator, DD-E and CD-F were informed of the concern of more than 14 hours between the supper meal and breakfast the next day without a nourishing snack. The Dietary Service Hours sign was given to the administrator for review. Informed there should be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime. The dietary manager acknowledged the snacks available to residents at bedtime would not be considered nourishing. The administrator was unaware and stated mealtimes would be addressed. Facility Mealtime policy dated 9/2012, indicated it was the policy to serve meals to meet the standards of the surveying agencies specifying no more than 14 hours between the evening meal one day and the breakfast meal of the next day. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policy and procedure (if needed) and create a process to ensure there is no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime. The administrator or designee could audit times between evening meal and breakfast and report the results of the audits to QAPI (quality assurance and performance improvement) to ensure appropriate oversight and/or need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21030		08/01/2026

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21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe, sanitary and comfortable environment for 1 of 1 residents (R2) whose room was unkept and had resident care items placed on the floor. In addition, the facility failed to perform daily cleaning in the kitchen which had the potential to affect 54/56 residents who received food from the kitchen. Findings include: R2 R2’s face sheet received on 6/10/26, included diagnoses of diabetes, dementia, and chronic gastritis (inflammation of stomach lining). R2’s quarterly Minimum Data Set (MDS) assessment dated 3/25/26, indicated intact cognition, clear speech, could understand and be understood. R2 was able to eat independently and required substantial assistance or was dependent on staff for activities of daily living (ADLs). R2 did not walk. R2’s physician orders dated 9/24/25, indicated to apply foot to calf wraps (black) at bedtime. Orders dated 3/23/26, indicated Ready Wraps firm and snug around foot, ankle, and calf in the morning. R2’s care plan dated 3/11/26, indicated an alteration in mobility related to diagnoses and transferred with a mechanical lift with assist of two staff using a large sling. During an interview and observation on 6/8/26 at 12:06 p.m., R2 was sitting in her recliner. Observed a number of items on the carpeted floor at the foot of her bed: mechanical lift sling, pillow without a pillowcase, blankets, heel boots. Behind the recliner was a piece of wood resembling a slider board, cloth tote bag, blanket. Along with a TV, the top of the built-in credenza was entirely covered with various items: R2’s personal items such as stuffed animals, empty vases, candle, figurines, three pair of slipper socks, two denture cups and mail. In addition,	21665	CORRECTED	08/01/2026

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21665	Continued from page 11 facility supplies: two stacks of briefs, two packages of wipes, gait belt, partial package of 4 x 4 dressings, a spray bottle of wound cleanser and chux (absorbent disposable pads). R2 stated staff didn't have time to straighten up her room. During an observation and interview on 6/9/26 at 1:39 p.m., together with nursing assistants NA-A, NA-B, and the director of nursing (DON), entered R2's room to observe items on the floor and the clutter on the credenza. Informed of observation the morning prior with items on the floor. The items that had been on the floor were now heaped on R2's bed. The DON stated staff took items off R2's bed in the evening and put them in her recliner and in the morning, put them back on her bed. With regard to the credenza, the DON stated she expected nurses to put wound supplies away in cupboard and for NAs to put briefs and wipes away. The DON stated extra blankets should be put in her closet. The DON admitted the room lacked storage surfaces for things like heel boots and the sling. During an interview on 6/9/26 at 1:44 p.m., NA-B stated R2 liked lots of blankets because she was usually cold, adding there wasn't enough room for everything and admitted staff could do a better job putting away their supplies. NA-B stated the blankets that had been on the floor the day prior were sent to laundry. During an interview on 6/9/26 at 6:55 p.m., R2 stated she didn't like when staff put things on the floor and didn't like all of the items on the credenza, adding she didn't have the ability to clean up it up herself. R2 stated staff should put their things away. During an interview on 6/10/26 at 7:35 a.m., housekeeper (H)-A stated she cleaned R2's room, and frequently there were items on the floor. H-A acknowledged seeing blankets, pillow, sling and heel boots on the floor, "every day." If R2 was in bed, she put those things on her recliner and if she was in her recliner, put things on her bed -- adding there weren't enough places to store things. To clean under everything on the credenza, H-A stated she picked up one item at a time, wiped under it and set it back down. H-A stated briefs and wipes were commonly on the credenza. During an interview and observation on 6/10/26 at 9:40 a.m., the credenza had about 50% less items/clutter on it. R2 stated it was much better, "I like it." No medical supplies/briefs/wipes were on the credenza. Heel boots, pillow, etc., were on the bed.	21665		08/01/2026

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21665	Continued from page 12 Facility Personal Belongings policy dated 5/2026, indicated residents were encouraged to personalize their rooms to create a home-like environment. Residents had the right to retain and use personal clothing and possessions as space permitted, provided they did not infringe on the health, safety, or rights of others. At times, a resident's room may need to be cleaned or reorganized. KITCHEN During initial kitchen tour on 6/8/26 at 6:25 a.m., with cook (C)-A, observed a dusty 8-inch black fan blowing toward food prep area on center island (no food was being prepped at that time). Observed smudges/smears on upper and lower metal cabinet doors, microwave door, and dried liquid drippings down the side of metal cabinet next to the oven. Crumbs on ledge of oven door. Crumbs on the bottom shelf of metal transport cart, crumbs on shelving inside lower metal cabinets. Box fan sitting on top of a yellow rubber receptable on wheels, not turned on, but with grayish material on the blades. Observed the solid surface flooring with non-skid surface; original color appeared to be taupe, but many areas were gray/blackish. Crumbs and debris were on the floor prior to food prep starting for the day. C-A stated dietary staff cleaned the kitchen daily and did a deep clean twice a year. During an interview on 6/9/26 at 10:29 a.m. dietary director (DD)-E and regional culinary director (CD)-F, were informed of concerns with cleanliness in the kitchen. Initially DD-E stated the reason was nursing staff entering the kitchen after hours but admitted that wouldn't account for crumbs inside cupboard shelves, and dirty stainless steel cupboard doors. CD-F stated the responsibility fell to him too; he was supposed to come monthly for a mock survey, but due to his workload, hadn't been able to. DD-E stated there were daily cleaning duties assigned to the cook and dietary aide. Reviewed completed checklists from a folder in her office, titled Closing List for Culinary. One half of the checklist indicated duties for the dietary aide and the other half for the cook. Duties included sweeping, wiping down counters and microwave inside and out, mopping, wiping down all sliding cabinet doors. For June, checklists indicated duties were done on only 6/1/26, 6/3/26, and 6/8/26, and of those, only the aides completed their duties; the cook duties were not initialed as having been completed. DD-E stated if the form had not been completed, she would assume the duties had not been done.	21665		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/10/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH CARE, LLC	**201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21665	Continued from page 13 Completion of daily Closing List for Culinary: April - completed 15/30 days, May - completed 19/31 days, and June partially completed 3/8 days. During a telephone interview on 6/9/26 at 11:38 a.m., registered dietician (RD)-G was informed of findings related to cleanliness. RD-G stated she was more on the clinical nutrition side and CD-F did the kitchen audits. RD-G had not been aware CD-F had not been able to do the audits due to workload. RD-G was not aware the kitchen had a daily end of shift checklist to complete for the day and evening staff. RD-G stated she would discuss concerns with DD-E and CD-F. During an interview on 6/10/26 at 10:47 a.m., with administrator, DD-E and CD-F, informed of cleanliness findings. The administrator had not been aware and stated they would address it. Facility Cleaning and Disinfection policy dated 9/12, indicated countertops, work surfaces and hard surfaces were to be wiped of excess particle of food, sprayed with a disinfectant solution and re-washed and wiped dry. Facility Sanitization policy dated October 2008, indicated the food service area would be maintained in a clean and sanitary manner. All kitchen areas would be clean. All counters and shelves would be kept clean. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policy and procedure (if needed) and re-educate staff to ensure resident rooms and the kitchen provide a safe, functional, sanitary and comfortable environment for residents. The administrator or designee could audit cleanliness and report the results of the audits to QAPI (quality assurance and performance improvment) to ensure appropriate oversight and/or need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		08/01/2026