Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 17, 2025

Administrator
Oaklawn Care & Rehabilitation Center
201 Oaklawn Avenue
Mankato, MN 56001

RE: CCN: 245517
Cycle Start Date: April 16, 2025

Dear Administrator:

On June 11, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2025

Administrator
Oaklawn Care & Rehabilitation Center
201 Oaklawn Avenue
Mankato, MN 56001

RE: CCN: 245517
Cycle Start Date: April 16, 2025

Dear Administrator:

On April 16, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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, Minnesota 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 July 16, 2025 (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 October 16, 2025 (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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	C 04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/14/25-4/16/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		5/23/25

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

Electronically Signed | 05/16/2025

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

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E 037	Continued From page 1 arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training	E 037		

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E 037	Continued From page 2 program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the	E 037		

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E 037	Continued From page 3 following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:	E 037		

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E 037	Continued From page 4 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide emergency preparedness (EP) training to 5 of 5 new hires (trained medication aide (TMA)-A, TMA-C, licensed practical nurse (LPN)-A, nursing assistant (NA)-C and NA-D) reviewed that was specific to the	E 037	Plan of Correction E037 Credible Allegation of Compliance: Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not	

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E 037	Continued From page 5 facility and consistent with staff roles. This had the potential to affect all 50 residents residing in the facility. Findings include: Document titled Employee information dated 4/14/25, indicated LPN-A date hired 2/5/25 NA-C date hired 1/27/25 NA-D date hired 1/27/25 TMA-A date hired 2/17/25 TMA-C date hired 3/28/25 On 4/16/25 at 1:48 p.m., the administrator stated new hires received EP training via an online education, but did not receive EP training that was specific to the facility and their roles. The Facility Emergency Operations Plan (EOP), dated 1/2024, indicated all staff members are provided training upon orientation and at a minimum of twice per year as it relates to emergency preparedness plan are responsible for understanding the scope of the emergency plan and the role, they play in implementing its procedures.	E 037	constitute an admission of guilt or liability by the facility and is submitted solely in response to regulatory requirements. Corrective Action for Affected Individuals: All new employees will receive training in Emergency Preparedness (EP) during orientation. The five individuals who were affected by this practice LPN-A, NA-C, NA-D, TMA-A, and TMA-C all received site specific EP training at all staff on 5/6,/5/7, and 5/8. Identification of Others at Risk: Employees have been re-educated on the facilitys emergency preparedness procedures. Ongoing education will be provided to all new hires as a part of their orientation process. Systemic Changes: The facility will conduct a tabletop drill to assess staff understanding of emergency procedures to ensure understanding, and also be quized on site specific EP training to ensure understanding. Emergency preparedness education will be reinforced at staff meetings, and we will monitor at our quartly QAPI meetings.	
F 000	INITIAL COMMENTS On 4/14/25-4/16/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		

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F 000	Continued From page 6 The following complaints were reviewed with NO deficiencies cited: H55172734C (MN00102617) H55173088C (MN00112334) 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. 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.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure professional standards of practice were followed during administration of eye drops for 3 of 3 residents (R12, R15, R106) observed for medication administration. Findings include: R12's annual Minimum Data Set (MDS) assessment dated 3/18/25, indicated R12 was	F 658	Credible Allegation of Compliance: Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute an admission of guilt or liability by the facility and is submitted solely in response to regulatory requirements. Corrective Action for Affected Individuals: Immediate reeducation was provided to nursing staff responsible for administering	5/23/25

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F 658	Continued From page 7 cognitively intact, no rejection of care, required, maximal assistance with personal hygiene, and diagnoses included progressive neurological conditions, hemiplegia or hemiparesis (weakness or partial paralysis on one side of the body), and multiple sclerosis (central nervous system autoimmune condition. Damage to myelin causes symptoms like muscle weakness and vision changes) . R12's care plan dated on 4/1/25, did not indicate any care needs related to her eyes. R12's medication review report printed 4/15/25, indicated Artificial Tears Ophthalmic Solution 1-0.3% (Propylene Glycol-Glycerin) instill one drop in left eye three times a day for dry eye and instill two drop in right eye as needed for as needed for dry eyes. R15's quarterly MDS dated 3/31/25, indicated R15 had moderately impaired cognition, no rejection of care, dependent on staff for personal hygiene and diagnosis included hemiplegia or hemiparesis. R15's care plan dated on 4/1/25, did not indicate any care needs related to her eyes. R15's medication review report printed 4/15/25, indicated Refresh Plus Ophthalmic Solution (Carboxymethylcellulose Sodium) instill one drop in both eyes four times a day for red puffy eyes. On 4/14/25 at 7:05 p.m., R15 was laying in bed and registered nurse (RN)-C placed gloves on both and explained to R15 she was administering her eye drops. RN-C placed the tip of the eye drop bottle at the inner corner of each eye to	F 658	eye drops to R12, R15, and R 106. Eye drops will be administered per Monarch's Eye Drop, Ointment, and Gel Medication procedure. Identification of Others at Risk: All residents who receive eye drops have the potential to be affected by this deficient practice. Systemic Changes: Nurses and Trained Medication Aides (TMAs) have been re-educated on Monarch's Eye Drop, Ointment, and Gel Medication procedure and expectations of using the correct technique for administering eye drops. Quality Assurance: Director of Nursing or designee will conduct random audits to ensure compliance 3x weekly for 1 week, weekly for 3 weeks, monthly for 2 months, and will review with QA committee for further recommendations	

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F 658	Continued From page 8 instill the drops. RN-C was not observed to pull down either lower eye lid to administer the eye drop in the pocket of the lower eye lid. On 4/14/25 at 7:23 p.m., RN-C stated the correct technique for eye drop administration included pulling the lower eye lid down and creating a pocket of the lower eye lid to place the eye drop. RN-C confirmed during R15's eye drop administration she did not pull the lower eye lid down to create a pocket. On 4/15/25 at 8:08 a.m., R12 was laying in bed and trained medication aide (TMA)-A stated she had R12's eye drops. TMA-A placed gloves on both hands and placed the tip of the eye drop bottle at the inner corner of each eye to instill drops. A drop was observed to run down R12's right side of her face. TMA-A was not observed to administer the eye drop in the pocket of the lower eye lids or attempt to place the drop in the pocket of the lower lid. On 4/15/25 at 8:47 a.m., TMA-A confirmed she administered R12's eye drops without pulling down the lower lids, and stated the correct administration for eye drops was to pull down the lower lid of the eye. TMA-A stated R12 does not like when we touch her face. On 4/15/25 at 8:50 a.m., R12 stated she would not care if staff touched her eye lids when administering eye drops if staff wore gloves. On 4/15/25 at 8:57 a.m.,, licensed practical nurse (LPN)-B, known as the care coordinator, stated the correct eye drop administration included pulling the lower eye lid down to make a pocket. LPN-B stated R12 was known to not want her	F 658		

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F 658	Continued From page 9 eyes touched and would expect staff attempt to pull the lower eye lid down during the administration of eye drops. On 4/15/25 at 10:32 a.m., the director of nursing (DON) stated during eye drop administration the lower eye lid was expected pulled down to form a pocket in the center of the lower eye lids. The DON stated R12 is known not to like her face touched, however would expect stuff to attempt to pull the lower lid down and explain the process to R12 and expected the care plan to address R12's refusal of her face touched during eye drop administration. The DON confirmed R12's care plan did not include R12's refusal of her face touched during eye drop administration. The DON stated R15's eye drop was expected performed with the lower lid pulled down to create a pocket for the eye drop administration. The DON stated during staff orientation eye drop administration was completed. R106's facesheet printed on 4/16/25, included diagnoses of glaucoma and ocular pain in right eye. R106's admission MDS assessment dated 4/7/25, indicated R106 was cognitively intact, had clear speech, could understand and be understood. R106's relied on staff for assistance with most activities of daily living. R106's physician orders included Latanoprost Ophthalmic Solution 0.005 % instill 1 drop in both eyes at bedtime for glaucoma. R106's care plan, last reviewed on 4/1/25, did not include diagnosis of glaucoma.	F 658		

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F 658	Continued From page 10 During an observation and interview on 4/14/25 at 7:19 p.m., observed TMA-A place an eye drop into each of R106's eyes. TMA-A placed the tip of the bottle in the inner corner of both eyes and instilled the drops, rather pulling down the lower lid and placing the drop midline in the lower lid pocket. TMA-A stated she was trained to place eye drops in the inner corner. TMA-A was unaware of facility policy regarding instilling eye drops. During an interview on 4/16/25 at 10:25 a.m., the DON described the steps of properly instilling drops in the eye, including having the resident tilt their head back, gently pulling down the lower lid and placing the drop in the pocket of the lower lid. The DON stated proper administration of eye drops was something a nurse or TMA would have learned in training. Facility Eye Drop, Ointment, and Gel Medication Administration policy undated, indicated with a gloved finger, gently pull-down lower eyelid to form "pouch," while instructing resident to look up. Place other hand against resident's forehead to steady. Hold inverted medication bottle between the thumb and index finger and press gently to instill prescribed number if drops into "pouch" near outer corner of eye. Do NOT let the tip of the dropper touch the eye or any other surface. If resident blinks or drop lands on cheek, repeat administration	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		5/23/25

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F 677	Continued From page 11 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide shaving for 1 of 1 resident (R45) who was dependent on staff for assistance with grooming and personal hygiene. Findings include: R45's facesheet dated printed 4/16/25, indicated diagnoses included muscle weakness, pain, high blood pressure, and heart failure. R45's quarterly Minimum Data Set (MDS) assessment dated 2/6/25, indicated R45 was cognitively intact, used a wheelchair, independent with eating, dependent for bathing and personal hygiene. R45's care plan printed 4/16/25, indicated R45 required staff assist of one for toileting, oral care, bathing, and personal hygiene. During interview and observation on 4/14/25 at 1:53 p.m., R45 had 6 visible chin hairs measuring varying lengths up to ½ inch long. R45 had a razor on her bedside table. R45 stated she did not like having chin hairs and wanted staff to shave her chin but thought staff were too busy. During interview and observation on 4/15/25 at 8:39 a.m., R45 was seated in her wheelchair eating breakfast. R45 was fully dressed and groomed for the day, but still had visible chin hairs. R45 stated staff had not offered shaving of her chin hairs while assisting her with grooming that morning.	F 677	Credible Allegation of Compliance: Please accept the following as the facilitys credible allegation of compliance. This Plan ofCorrection does not constitute an admission of guilt or liability by the facility and issubmitted solely in response to regulatory requirements. Corrective Action for Affected Individuals: R45 was provided assistance with shaving and was shaved 4/15/25. Care plan was updated to show that resident needs assistance with shaving. Identification of Others at Risk: All residents who require assistance have the potential to be affected by this deficient practice: Systemic Changes: Staff have been educated on the importance of regular grooming and maintaining facial hair hygiene. A house audit will be completed by DON or designee to determine other residents in similar situations and will be offered shaving if they are not capable, and their care plan will be updated. Quality Assurance: The facility will perform weekly audits for four weeks to ensure residents are groomed and shaved appropriately and consistently. Will review with QAPI team for further recommendations.	

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F 677	Continued From page 12 During interview on 4/15/25 at 9:44 a.m., nursing assistant (NA)-E stated she was unaware R45 had long chin hairs. NA-E stated she had heard someone talking about shaving R45 yesterday and they were going to take care of it (shaving) on evening shift. NA-E further stated she did not notice R45 needed to be shaved this morning, did not offer to shave her chin hairs when she assisted her with morning grooming, and she should have shaved her chin if that was what R45 wanted. During interview and observation on 4/15/25 at 1:40 p.m., R45's chin had been shaved. R45 stated she felt so much better and asked if she looked better. R45 was smiling throughout the conversation and showing her chin. During interview on 4/16/25 at 12:31 p.m., registered nurse (RN)-D stated she expected residents to be shave at least weekly and not have visible chin hairs if they did not want chin hairs. RN-D further stated shaving should be part of morning cares. During interview on 4/16/25 at 12:41 p.m., director of nursing (DON) stated she would expect shaving weekly and if a resident wanted to be shaved they should be shaved, especially if chin hair was visible to others. A facility policy on shaving and grooming was requested by not received.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		5/23/25

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F 689	Continued From page 13 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe smoking area, extinguishing of cigarettes in designated container, and monitoring of designated smoking area for 2 of 2 residents (R20 and R18) reviewed for smoking. Findings include: R18's facesheet printed 4/16/25, indicated diagnoses of spina bifida, nicotine dependence, and obesity. R18's admission minimum data set (MDS) assessment dated 3/10/25, indicated intact cognition, use of wheelchair, dependent for bathing, and setup assistance for personal hygiene. R18's care plan printed 4/16/25, indicated resident currently smoked and would smoke safely in designated areas per facility policy. R20's face sheet printed 4/16/25, indicated diagnoses of type two diabetes mellitus and malnutrition. R20's annual MDS dated 4/8/25, indicated intact cognition, use of wheelchair, substantial assistance with toileting hygiene, and partial	F 689	Credible Allegation of Compliance: Please accept the following as the facilitys credible allegation of compliance. This Plan ofCorrection does not constitute an admission of guilt or liability by the facility and issubmitted solely in response to regulatory requirements. Corrective Action for Affected Individuals: The facility will ensure that the resident R20 and R18 environment remains free from accident hazards and that each resident receives adequate supervision to prevent accidents. Identification of Others at Risk: Residents who smoke have the potential to be affected by this deficient practice. Systemic Changes: Staff have been re-educated on the importance of maintaining a safe smoking area. The smoking policy will be updated to say that "facility is a non smoking facility, but if a resident wishes to do so there is safely designated spot on the north patio outside" This patio is outlined in orange paint. Quality Assurance:The facility will do three	

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F 689	Continued From page 14 assistance with personal hygiene. R20's care plan printed 4/16/25, indicated resident currently smoked and would smoke safely in designated areas per facility policy. During observation on 4/16/25 at 7:14 a.m., R18 and R20 were outside in the designated smoking area at the facility. R18 and R20 were smoking independently and extinguished cigarettes safely in designated disposal container. On and surrounding the designated smoking area were approximately 100 cigarette butts (ends of smoked cigarettes) in the grass, under trees, and on the patio. During interview on 4/16/25 at 8:46 a.m., R18 stated he always put his cigarette butt in the designated container and was not sure where the loose cigarette butts came from. During interview on 4/16/25 at 9:04 a.m., R20 stated there was a previous resident who threw her cigarette butts everywhere and never put them in the designated disposal container. The previous resident had discharged from the facility in December 2024 and had not returned. R20 further stated staff would not know about the mess because they never go back on the smoking patio. During interview on 4/16/25 at 10:00 a.m., housekeeping director stated that she thought maintenance would have been overseeing the smoking area, but no one had done it. Housekeeping director further stated her staff had not been monitoring the smoking area or any outside areas but had been asked to pick up all the cigarette butts in the smoking area "few	F 689	aduits weekly for two weeks, and then will do weekly audits for 3 weekly audits. Will continue to monitor safty of smoking patio on weekly basis to be sure its accident free. A security camera has also been installed to watch the area with a 24 hour monitoring screen on north nurses unit.	

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F 689	Continued From page 15 minutes ago." During interview on 4/16/25 at 8:35 a.m., administrator stated the facility was labeled as a non-smoking facility by signs on the facility door stating non-smoking facility and by notice in the facility policy, but they did let residents smoke. Administrator further stated there was a canister for disposing of cigarettes on the patio and that was where residents were to put their extinguished cigarettes. Administrator was unaware of the cigarettes being thrown on the dry grass, leaves, and under the trees. Administrator agreed cigarettes could potentially start fires if not disposed of properly and could be a safety concern, and confirmed no staff routinely check on the condition or safety of the smoking area. Administrator further stated the maintenance director was new and had not been trained to clean up the smoking area. Facility Oaklawn Rehabilitation Center Smoking Policy dated 8/15/24, indicated the following: Policy Statement: It is the policy of Oaklawn Rehabilitation Center to provide a safe an healthy environment for tenants, staff, and visitors by limiting the use of tobacco and e-cigarette products on it's campus, while also being respectful of the right of each resident to exercise his/her autonomy regarding what they consider to be an important facet of their life. Oaklawn is designated as a non-smoking facility, but due to the lack of safe access to a smoking area off the facility grounds, the back north patio will be designated as a safe smoking location for residents to smoke and dispose of smoking waste. 3. Resident Smoking -Residents are required to use appropriate	F 689		

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F 689	Continued From page 16 disposal containers for smoking materials, such as cigarette butts and matches. 5. Enforcement and Compliance -Staff members are responsible for enforcing this policy and addressing any violations. Residents, staff, and visitors found in violation of this policy will be subject to corrective actions, which may include verbal warnings, written notices, or other measures as deemed appropriate by management.	F 689		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the	F 801		5/23/25

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F 801	Continued From page 17 supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a	F 801		

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F 801	Continued From page 18 course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that in the absence of a full-time registered dietician (RD), the culinary services director (CSD)-B was certified to oversee nutrition and food services. This had potential to affect all 45 residents who received meals from the kitchen. Findings include: During the initial kitchen tour on 4/14/25 at 9:40 a.m., CSD-B who had been employed in this role for two years, stated she was not a certified dietary manager (CDM). CSD-B stated she had been enrolled in the course at one time but was not able to complete it. During an interview on 4/15/25 at 11:25 a.m., CSD-B stated the administrator had registered her for the CDM course that morning (4/15/25), and she was now enrolled to take the course. During an interview on 4/15/25 at 2:39 p.m., registered dietician (RD)-C stated she worked	F 801	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The culinary manager has been re-enrolled in an approved Certified Dietary Manager (CDM) program. Will continue to have regional dietian support the facility while culinary manager finishes CDM course. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. The measures the facility will take or	

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F 801	Continued From page 19 part-time at the facility, usually one or two days a week, and communicated frequently with CSD-B via email or phone. RD-C acknowledged CSD-B was new to resident clinical issues, such as monitoring resident weights, but "did well on the kitchen side." Facility Culinary Services Director job description, undated, indicated qualifications included: must be a graduate of or currently enrolled in an approved culinary services course that meets the requirements for State and Federal long-term regulations.	F 801	systems the facility will alter to ensure that the problem will be corrected and will not recur: The facility has re-enrolled the culinary manager in an approved Certified Dietary Manager course. Quality Assurance plans to monitor facility performance to ensure that corrections are achieved and maintained: The facility will review the progress of the culinary managers CDM course during quarterly QAPI meetings.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 812	Please accept the following as the	5/23/25

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F 812	Continued From page 20 review, the facility failed to ensure 2 of 2 refrigerator/freezers designated for resident food brought into the facility, were monitored to ensure food items were properly stored, labeled, and dated to reduce the risk of contamination and/or foodborne illness. This had the potential to affect any resident who utilized the refrigerator/freezers. In addition, the facility failed to ensure a culinary services cook (CSC)-A wore covering over beard to prevent hair from contaminating food, surfaces and utensils. This had the potential to affect all 45 residents who ate food prepared in the kitchen. Findings include: North Wing Resident Refrigerator: During an observation on 4/14/25 at 2:54 p.m., the resident refrigerator on the North wing was a side-by-side refrigerator/freezer. On the outside of the refrigerator was a sign that indicated: All items placed in this refrigerator must be in a sealed container with name and date. Perishable items are kept for 3 days. A sign on the freezer indicated: All items placed in refrigerator and freezer must be dated and labeled with room number or it will be discarded per department of health guidelines. In the refrigerator were the following items: -- Pizza in a box with a resident name but no date. -- Small Styrofoam container of an orange-colored substance. The container was not covered. No name or date were on the container. -- Small plastic dish of something unidentifiable, with a spoon in it and covered with plastic wrap. No name or date. -- Small cup of dark colored juice with a residents name and dated 4/9 (five days prior).	F 812	facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: All affected food items have been discarded, and all staff members have been re-educated on the requirement to wear beard nets. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur: The facility has re-educated the culinary manager on her responsibility to monitor the refrigerators and remove any undated or expired food items from both the north and south units.The facility has re-educated culinary staff on the requirement to wear beard nets while in the kitchen. Quality Assurance plans to monitor facility performance to ensure that corrections are achieved and maintained: The facility will conduct audits three times per week for two weeks, then weekly for two additional weeks.	

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	245517	A. BUILDING _____ B. WING _____	C 04/16/2025

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F 812	Continued From page 21 -- Open bottle of Fairlife protein drink; no name or date. -- DoorDash meal in a bag with name but no date. -- Small container of orange substance with cover. No date, no name. -- Soup in a large Ziplock bag, name but no date. In the freezer: -- A light green frozen drink. No name or date. -- Multiple packages of opened frozen hamburger patties - room number, but no date. South Wing Resident Refrigerator: During an observation on 4/14/25 at 3:15 p.m., on the South wing, the culinary services director (CSD)-B was standing with the refrigerator door open, preparing to mark food with a marker. Prior to doing so, the following items were noted in the refrigerator: -- 3 small Ziploc bags of peeled, overripe bananas; no name or date. CSD-B stated a staff member was going to take them home to make banana bread. -- Store bought container of cantaloupe with room number and no date opened. Seal indicated best by 4/5/25. -- Store bought container of watermelon with room number and no date opened. Seal indicated best by 4/3/25 -- Store bought mixed berries, no name or date. -- Plastic container with food - pasta with sauce - no name or date. CSD-B stated it was likely an employee's food and shouldn't be in the refrigerator. CSD-B stated no one was assigned to monitor the resident refrigerator/freezers - it was everyone's responsibility to monitor them and discard food items not meeting requirements.	F 812		

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F 812	Continued From page 22 During subsequent observations on 4/14/25 at 6:42 p.m., (north wing) and at 7:34 p.m., (south wing), the refrigerators and freezers were almost empty after being cleaned out by CSD-B. Hairnet During an observation and interview on 4/14/25 at 11:58 a.m., observed CSC-A who had a full beard, carrying resident meals from the kitchen to the dining room without a beard cover. CSD-B stated she did not know if CSC-A was supposed to cover his beard, and didn't know if the facility had a policy on that. In the meantime, CSD-B gave CSC-A a hairnet to place over his beard. CSC-A also stated he did not know his beard should be covered. Facility Food Brought into Facility policy dated 9/2012, indicated the policy was to address food brought in from the outside with the intent to serve it to all residents. The policy did not include food brought in from the outside for individual residents and stored in resident refrigerator/freezers in common areas. Facility Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy dated 10/2017, indicated hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. Facility Food Preparation and Service policy dated 4/2019, indicated food and nutrition services staff wear hair restraints (hair net, hat, beard restraint) so that hair does not contact food.	F 812		

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		5/23/25

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F 880	Continued From page 24 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was donned (put on) and doffed (removed) appropriately for 1 of 1 resident (R206) who had been in transmission-based precautions (TBP) due to testing positive for Covid-19. Findings include: R206's facesheet printed on 4/16/25, indicated	F 880	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R206 no longer requires transmission based precautions (TBP) for	

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F 880	Continued From page 25 R206 was admitted on 4/10/25, with a diagnosis of Covid-19. R206's physician orders dated 4/11/25, indicated: due to Covid positive status, R206 was to remain on enhanced respiratory precautions and strict isolation during the contagious stage. R206's care plan dated 4/11/25, indicated R206 was on enhanced respiratory precautions related to Covid-19 infection. Staff would follow enhanced respiratory precautions. During an observation on 4/14/25 at 6:25 p.m., observed nursing assistant (NA)-A don PPE to go into R206's room. NA-A donned all appropriate PPE except eye protection. At 6:28 p.m., NA-A exited the room with all PPE having been removed prior to exiting the room. Following this observation, a sign on R206's door indicated R206 was in Enhanced Respiratory Precautions, and gown, facemask or N95, eye protection, and gloves were required when entering the room. NA-A did not don eye protection. There was no eye protection in or on the PPE cart outside R206's room. Further, NA-A had doffed her N95 mask in the room rather than after exiting the room, as directed by the CDC (Centers for Disease Control and Prevention) doffing guidance. NA-A was no longer available for interview. During an interview on 4/14/25 at 7:13 p.m., NA-B stated the required PPE for entering R206's room was gown, N95 mask, face shield and gloves. While standing together looking at R206's PPE cart, NA-B stated, there were no face shields on the cart and went and obtained some, putting them on the top of the cart.	F 880	dx COVID. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents requiring transmission based precations for dx COVID have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur: The facility does not currently have any residents who require transmission based precations for dx COVID. Staff have been re educated on Monarch's COVID policy, the CDC PPE Sequence, and expectations for wearing eye protection and doffing PPE when caring for residents requiring transmission based precations of Enhanced Respiratory Precautions for dx COVID. Quality Assurance plans to monitor facility performance to ensure that corrections are achieved and maintained: Director of Nursing or designee will conduct random audits to ensure compliance 3x weekly for 1 week, weekly for 3 weeks, monthly for 2 months, and will review with QA committee for further recommendations.	

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F 880	Continued From page 26 During an interview on 4/15/25 at 7:39 a.m., registered nurse (RN)-A, who was also the nurse manager for the unit on which R206 resided, was informed of the observation of an NA entering R206's room without eye protection. RN-A stated they must have run out of eye protection. RN-A stated she would expect staff to know to don all required PPE, including eye protection before entering the room of a resident in TBP for Covid-19. When asked how PPE should be doffed, RN-A looked at CDC doffing instructions and stated PPE should be doffed before exiting the resident room except for the respirator (N95 mask); the respirator (N95 mask) should be removed after leaving the resident room and closing the door. RN-A stated staff should be aware of that - removing the N95 mask after exiting the room as the doffing instructions were posted on the back side of R206's door for them to utilize. RN-A acknowledged with the small size of the print; staff might not notice those instructions. RN-A also acknowledged staff had training on doffing but could have forgotten that step. During an observation and interview on 4/15/25 at 9:46 a.m., observed licensed practical nurse (LPN)-A exit R206's room with all PPE doffed, including N95 mask. LPN-A stated she wasn't aware she should doff the N95 mask after exiting the room, adding, I guess I just forgot that. During an observation and interview on 4/15/25 at 5:12 p.m., observed NA-B exit R206's room with all PPE doffed, including N95 mask. NA-B acknowledged she removed all the PPE including the N95 mask before exiting the room. NA-B stated she wasn't aware she should doff the N95	F 880		

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F 880	Continued From page 27 mask after exiting the room. During an interview on 4/16/25 at 4:49 p.m., the director of nursing (DON) and RN-B, who was also the regional nurse consultant were informed of findings. RN-B stated staff were trained on donning and doffing and would expect they adhere to proper procedure. Facility policy on doffing for TBP was requested and the CDC guidelines were received. The guidelines were undated and titled: HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2 and indicated: to remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		5/23/25

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F 883	Continued From page 28 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pneumococcal	F 883	Please accept the following as the facility's credible allegation of compliance.	

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F 883	Continued From page 29 (PCV20) vaccine was offered or administered as recommended by the Centers for Disease Control (CDC) for 1 of 5 residents (R157) reviewed for immunizations. Findings include: R157's facesheet printed on 4/16/25, indicated and admission date of 4/7/25, and diagnoses of heart failure, muscle weakness, fatigue, and obesity. R157's admission Minimum Data Set (MDS) dated 4/11/25, indicated intact cognition and no rejection of care. R157's physician's orders printed on 4/16/25, indicated a past history of pneumonia, unspecified organism. R157's care plan dated 4/7/25, indicated a self care deficit related to weakness and visual impairment and need for assistance with dressing, personal hygiene, and bathing. During record review, there was no documentation in R157's EMR (electronic medical record) for the PCV 20 vaccine or evidence the vaccine had been offered or refused. During interview on 4/16/25 at 2:56 p.m., director of nursing (DON) stated she expected the PCV 20 vaccine to be offered to all residents based on current CDC guidelines and was not sure why this was missed for R157. DON later stated she had now offered the PCV 20 vaccine to R57. DON further stated R157 accepted and would receive the offered vaccine.	F 883	This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R157 was offered and administered the pneumococcal (PCV20) vaccine on 04/20/25. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who are not up to date with their pneumococcal vaccine have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur: A full house audit was completed to identify residents who were not up to date with their pneumococcal vaccine. Residents who met criteria were offered PCV20 vaccination and administered to those who consented. Nurse leaders were re educated on Monarchs Pneumococcal policy and downloaded the CDC app called PneumoRecs as a tool to know what vaccines are due based on when residents last had them, which follows The CDC Recommended Adult Immunization Schedule 2025, and expectations to ensure pneumococcal vaccination is offered and administered as	

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F 883	Continued From page 30 Facility Pneumococcal Policy updated 2/2024, indicated the following: It is the practice of the Health Care Facility to offer all residents the pneumococcal vaccines to aid in the prevention of pneumococcal/pneumonia infections. The policy further indicated the facility would follow recommendations of the CDC.	F 883	recommended by the CDC. Quality Assurance plans to monitor facility performance to ensure that corrections are achieved and maintained: Director of Nursing or designee will conduct random audits to ensure compliance weekly for 4 weeks, monthly for 2 months, and will review with QA committee for further recommendations.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/17/2025. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/2025

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

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OAKLAWN CARE & REHABILITATION CENTER	**201 OAKLAWN AVENUE** **MANKATO, MN 56001**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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 52 at the time of the survey.	K 000		

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	245517	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2025**

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K 000	Continued From page 2 The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING	K 222		5/23/25

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K 222	Continued From page 3 ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1, 7.2.1.5.1, 7.2.1.4.5.1, 7.2.1.5.3, 7.2.1.5.10, and 7.2.1.5.10.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 04/17/2025 at 12:30 PM, it was revealed by observation that the latch on the gate to exit out of the smoking area was on the outside of the	K 222	The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The maintenance director removed the latch on the outside of two of the patio gate doors, one on each patio. He replaced them with a push exit bar on the inside of the patio door gates. The maintenance director removed the emergency push bar from the exit door in	

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K 222	Continued From page 4 gate and did not have an obvious method of operation and was not readily operated under all lighting conditions. 2. On 04/17/2025 at 12:38 PM, it was revealed by observation that the exit door out of the dining room would not open, and the Maintenance Director had to remove the hinge pins to get the door open. 3. On 04/17/2025 at 01:09 PM, it was revealed by observation that the latch on the gate in the exit discharge from the day room was on the outside of the gate and did not have an obvious method of operation, and was not readily operated under all lighting conditions. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 222	the dinning room and replaced it with a brand new one. Quality Assurance, plans to monitor facility performance to make sure that corrections are achieved and are permanent: The administrator will audit the patio gate doors to ensure they are in working condition and ensure they are visible from the inside of the gated area. The administrator will also audit the emergency door in the dinning room to ensure that it openes properly.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		5/23/25

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K 321	Continued From page 5 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/17/2025 at 12:51 PM, it was revealed by observation that the door to the soiled utility room near resident room 206 was propped open with a rubber mat. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K 321	The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility removed the rug from the soiled utility room on 4/17/24. Quality Assurance, plans to monitor facility performance to make sure that corrections are achieved and are permanent: The administrator and maintenance director walked the facility to ensure that no other rugs were holding doors open.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		5/23/25

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K 372	Continued From page 6 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, and 8.5.2.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/17/2025 at 11:24 AM, it was revealed by observation that the smoke barrier was not sealed between the roof and wall above the smoke barrier doors to the north wing. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K 372	The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The maintenance director rechecked and smoke barriers not sealed between roof and wall. Director used fire rated foam to seal the openings Quality Assurance, plans to monitor facility performance to make sure that corrections are achieved and are permanent: The administrator will audit smoke barrier walls to ensure there are no gaps and that they are completely sealed.	

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K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/17/2025 between 10:15 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that a fire drill was conducted during the first shift during the fourth quarter of 2024. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K 712	The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The fire drill was conducted on 10/11/24 at 10:30am. The drill was preformed as the system was put into test mode. The facility was able to prove this by following up with the monitoring company on 5/13/25 to show that a test was preformed in the month of October. Quality Assurance, plans to monitor facility performance to make sure that corrections are achieved and are permanent: To ensure that corrections are permanent	5/23/25

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K 712	Continued From page 8	K 712	an new column was added to document to "record documentation" to the fire alarm report monthly. This will be overseen by maintenance director and administrator.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1, 10.5.2.3.3, 10.2.4.2.1, and 10.2.4.2.1, NFPA 101	K 920	The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The maintenance director removed	5/23/25

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K 920	Continued From page 9 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70, (2011 edition), National Electrical Code, sections 400.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/17/2025 12:42 PM, it was revealed by observation that there was an extension cord that was cut and wired to power the temperature sensor for the freezer. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K 920	freezer and refrigerator temperature monitors that were configired with an extension cord. Quality Assurance, plans to monitor facility performance to make sure that corrections are achieved and are permanent: The maintinacne director will be doing monthly inspections to ensure that items are correctly wired in the facility.	