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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CIMU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00038

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/20/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Margueritte Meeker, Unit Supervisor 03/20/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 03/20/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/6/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/13/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on January 31, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On March 19, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 1, 2012 the Minnesota Department of Public Safety completed a PCR by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 26, 2012, effective as of March 19, 2012. Therefore, remedies outlined in our letter to dated February 9, 2012, will not be imposed. See the attached CMS-2567b for results of the March 19 and March 1, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 20, 2012 CMS Certification Number (CCN): 245517

Mr. Rick Krant, Administrator
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, Minnesota 56001

Dear Mr. Krant:

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

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

Effective March 19, 2012 the above facility is recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Susan N. Leppke

Susan N. Leppke, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4121 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 20, 2012

Mr. Rick Krant, Administrator
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, Minnesota 56001

RE: Project Number S5517023

Dear Mr. Krant:

On February 9, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 26, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 19, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 1, 2012 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 26, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 19, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 26, 2012, effective March 19, 2012 and therefore remedies outlined in our letter to you dated February 9, 2012, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5517r12.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245517	A. Building B. Wing	3/19/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/19/2012**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/19/2012**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/19/2012**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/19/2012**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/19/2012**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/19/2012**

Reviewed By State Agency	**Reviewed By** SNL/MM	**Date:** 03/20/2012	**Signature of Surveyor:** 03020	**Date:** 03/19/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/26/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245517	01 - MAIN BUILDING 01	3/1/2012

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	02/22/2012	ID Prefix Reg. # NFPA 101 LSC K0056	02/22/2012	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SNL/PS	03/20/2012	22373	3/1/2012
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/31/2012			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CIMU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00038

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/31/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marilyn Kaelke, HFE NE II 03/01/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 03/08/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/13/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on January 31, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4822

February 9, 2012

Mr. Rick Krant, Administrator
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, Minnesota 56001

RE: Project Number S5517023

Dear Mr. Krant:

On January 31, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Marge Meeker
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7317

Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 11, 2012, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 11, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by

the same deficient practice;

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 26, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 26, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5517s12.rtf

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Informal Dispute Requested

This facility has requested an Informal Dispute on the tag(s) identified below.

Facility (City) HFID#	Exit Date Being Disputed	Tag# - Scope/Severity Disputed
Oaklawn Health Care Center Mankato 00038	1/26/2012	~~F282 = D~~ ~~F334 = D~~

Both tags Removed

Larson, Monica (MDH)

From: rkrant@throcompany.com
Sent: Thursday, February 23, 2012 11:53 AM
To: *MDH_FPC-IDR
Subject: IDR Form

PROVIDER - 00038, OAKLAWN HEALTH CARE CENTER

IDR Type - IDR

Tags: FF 282 and F 334
Survey Date(Exit Date): 1/26/2012

Review will be conducted - In writing

Dates when facility cannot participate: None

Will attorney for facility be attending: No

No of persons attending:
Submitter Name: Rick Krant
Email:rkrant@throcompany.com

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 24, 2012

Mr. Rick Krant,
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, MN 56001

Dear Mr. Krant:

This letter acknowledges receipt of your request for Informal Dispute Resolution (IDR) of the deficiencies issued at a recent Minnesota Department of Health survey of your facility.

It is my understanding that you are contesting the validity of the following:

F282 = D F334 = D

I have assigned the responsibility for the IDR to Brenda Fisher. Brenda will contact you with the results of our review or feel free to contact her at 320-223-7338.

Sincerely,

Mary Absolon

Mary Absolon, Program Manager
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4100 FAX: (651) 215-9697

cc: Office of Ombudsman for Long-Term Care
Brenda Fisher, Unit Supervisor
Carol Moen, Assistant Program Manger
Monica Larson

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 000 8043 9055

April 12, 2012

Mr. Rick Krant, Administrator
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, MN 56001

Subject: Oaklawn Health Care Center - IDR
Provider # 245517
Project # S5517023

Dear Mr. Krant:

This is in response to your letter of February 22, 2012, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F282 and F334 issued pursuant to the survey event CIMU11, completed on January 26, 2012.

The information presented with your letter, the CMS 2567 dated January 26, 2012 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F282 (D) 42 CFR §483.20 (k)(3)(ii) Be provided by qualified person in accordance with each resident's written plan of care.

Summary of the facility's reason for IDR of this tag.
The facility indicated the nurse manager had provided education to R91 as directed by the current plan of care. The nurse provided education on the importance of shifting her weight, wheelchair repositioning, resting in bed or recliner between daily activities. This education was supported by the 10-12-11 documentation in R91 record.

Summary of facts.
R91 is alert and oriented and able to make decisions independently. R91 told the surveyor "I'm busy" and "there's three nurses on me all the time" regarding interventions. Review of the nursing notes indicated that on 10-12-11 the nurse identified R91's pressure ulcer on her coccyx and "staff will initiate hourly off loading as (resident name) allows, writer explained the importance of this..." The note continued to indicate they would encourage R91 to use her tilt electric wheelchair back and rest in bed or recliner between daily activities. The note identified other pressure ulcer prevention interventions and the "daughter was updated" and the facility would notify the physician assistant about the pressure ulcer and interventions. The care plan indicated to "Educate (R91) on causes of skin

breakdown including: transferring/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and repositioning." Interview with NA-B verified R91 was resistive to most interventions but staff continued to offer these interventions.

Summary of findings:
The nursing note of 10-12-11 identified interventions of "...hourly off loading as (resident name) allows, writer explained the importance of this..." The note identified R91 was educated on the importance of "hourly off loading." R91 was alert and orientated, able to make her own decisions, and identified herself as being "busy." The interview with NA-B verified R91 was resistive to most interventions but staff continued to offer.

This in not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies and subsequent licensing orders, 565 and 0900 were removed. The R91 example will also be removed from tag F314, 42 CFR §483.25 (c) Pressure Ulcers.

F334 (D) 42 CFR §483.25 (c)(2)(i) Influenza and pneumococcal immunizations

Summary of the facility's reason for IDR of this tag.
The facility indicates the family did receive education about the pneumococcal and influenza immunizations. The family was acting and speaking on R115 behalf due to R115 delirium upon admission on 1-6-12. The family refused these vaccinations on R151 behalf because R115 had a history of declining these immunizations in the past.

Summary of facts.
R115 was admitted on 1-6-12 with a diagnosis of delirium related to surgery and anesthesia. The facility Resident Vaccine Administration Consent Form, dated 1-6-12, identified "I have been given a copy and have read or have/had explained to me the information contained in the appropriate vaccine information material (fact sheets) about the disease and vaccine (s) indicated below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the indicated vaccine (s) and ask that the vaccine (s) be given to me." Below this section of the form has an area marked with an X that indicated, "I do not wish to have the vaccination at this time." The form is signed by R115 family member on 1-6-12.

Summary of findings:
The facility did give the family the option of the pneumococcal and influenza vaccines on 1-6-12 at admission due to R115 delirium. The family signed the sheet on 1-6-12 identifying they received the information, and chose not to have vaccinations completed due to R115 history of refusing these in the past. Although R151's delirium resolved and orientation improved there is no evidence to indicate R151 would have wanted to received the vaccines.

This in not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Brenda Fischer

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Facility and Provider Compliance
Telephone: 320-223-7338 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care
Carol Moen, Assistant Program Manager
Licensing and Certification File
Brenda Fischer, Statewide Survey Team Unit Supervisor

S5517023

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245517	A. Building B. Wing	REVISED 4-13-2012 3/19/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 03/19/2012	ID Prefix F0242 Reg. # 483.15(b) LSC	Correction Completed 03/19/2012	ID Prefix F0272 Reg. # 483.20(b)(1) LSC	Correction Completed 03/19/2012
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 03/19/2012	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 03/19/2012	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 03/19/2012
ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 03/19/2012	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 03/19/2012	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 03/19/2012
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 03/19/2012	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 03/19/2012	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 03/19/2012
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 03/19/2012	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/26/2012	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS REVISED 2567 AS A RESULT OF AN INFORMAL DISPUTE RESOLUTION The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	REVISED 4-13-2012	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services in a dignified manner related to visual limitations and the need for meal time assistance for 1 of 3 residents (R56) reviewed in the sample for dignity. Findings include: R56 did not receive meal time assistance in order to ensure a dignified experience when dining.	F 241		

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

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

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 R56 indicated during interview at 10:10 a.m. on 1/24/12, "they (the physician) called me legally blind." She further indicated that she has "gone blind since being here" and her vision had significantly deteriorated in the "last few months". She stated that one of her concerns was "They don't give me a lot of help at meals. I have a hard time feeding myself, getting the food on the fork and getting it to my mouth." R56 had multiple diagnoses including glaucoma and diabetes. During observation at 12:05 p.m. on 1/25/12, R56 wheeled into the dining room and with staff assistance was positioned at her table. R56 was provided hot water by staff and she independently placed her tea bag in the water. There was a bowl already on the table near her other glasses of milk and water. R56 pulled the bowl toward her and stated loudly enough to be easily heard "I don't know what we're eating." R56 then began to eat her lettuce salad, taking the first few bites easily. As there was less salad in the bowl, R56 used her opposite hand to feel inside the bowl for the lettuce and assist getting the lettuce onto the fork. As she pushed the lettuce onto the fork, she stated "I can't see it." R56 was able to feed herself the salad using both hands and feeling the food with her non-dominant hand. There was a scant amount of lettuce salad left in the bowl. At 12:30 p.m. R56 was provided a plate of food by dietary staff, without any verbal exchange or explanation of her food. R56 then asked her two table mates "What do we have to eat today? What's on my plate? Where is it?" R56 had pork	F 241		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2	F 241		

steak, beets, mashed potatoes with gravy, carrots and a slice of bread with butter. R56 was told by table mates what was on her plate; however they were uncertain what the meat was. R56 began to eat her food without staff assistance, feeling her way across her plate with her left hand and a fork in her right hand. Once she was able to feel the food on her plate, she began to eat with a fork. The meat remained a large chunk of meat and had not been cut up in any way. R56 stabbed her fork into the meat in order to break off an approximately 3 cm x 3 cm piece of meat which she placed in her mouth. After that piece of meat she made no further attempts to eat the meat. R56 continued to eat with both hands - her left hand assisted to push food onto the fork, which was held by her right hand. As she attempted to get her food onto the fork, her carrots and beets were pushed off of the plate onto the table. She would pick them up, place them back onto her plate and continue to eat, attempting to push them onto her fork with her free hand. At 12:50 p.m. R56 received her desert of peach cobbler. R56 again asked her table mates what she had to eat. Her table mates were uncertain what it was and as R56 poked her finger into the bowl of cobbler stated "I think it's something apple." R56 took one bite of cobbler getting only a small portion of the cobbler and whip cream with no peach as the peach kept slipping from the fork. R56 ate the one bite of cobbler and made no further attempts to eat. She had eaten approximately 50% of her meal and drank only her tea. The milk and water at the top of her plate remained untouched.

There was a nursing assistant in the dining room throughout the entire meal; however he was

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3	F 241		

feeding other residents at another table several tables away from R56. Multiple dietary staff were in and out of the dining room delivering food. Nursing staff members were in and out of the dining room, bringing residents, delivering medications and removing residents when they were done eating. Although there were multiple staff in the dining room, R56 received no clarifications on what she was eating or offers of assistance.

When interviewed at 1:50 p.m. on 1/25/12 after the observed meal, R56 stated "I get by - the girls at my table are really good about telling me what we're eating. I like to be independent. They rush away so quickly, they don't seem to have time to answer my questions. I just really want to do things for myself as much as I can. I don't want everyone to know I can't see."

Nursing assistant (NA) C was present in the dining room throughout the entire meal. He was asked specifically about R56's need for meal time assistance and her visual limitations. At 1:30 p.m. on 1/25/12, NA-C stated "She always eats 75% or so of her meals. I ask her how she's doing and she always talks about - I'm losing my vision - I can't see that kind of thing. But she always eats - unless she's sick or something."

Clinical Manager (CM) B was interviewed at 2:15 p.m. on 1/26/12 about R56's needs for meal time assistance and her visual limitations. She responded that dietary was looking into getting a dark plate in order to see her food better. She further indicated " I should make her an eye appointment to get her vision checked. I wasn't aware her sight was that bad. Her last

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4 ophthalmology appointment was 11/17/11 - but there was nothing specific about (R56's) visual ability. Part of what we talked about yesterday (in her scheduled care conference) was to have dietary explain food and use clock method when the food is provided to her."	F 241		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that residents had choices related to food and snacks for 5 of 5 residents (R25, R67, R56, R46, R28) in the sample reviewed for choices. Findings include: R46 reported during an interview at 10:55 a.m. on 1/24/12, that dietary staff " just serves the meal " and does not feel that she was given a choice of foods at meal times. R46 reported " would like to have a choice of food that she eats. " R46 had multiple diagnoses, including above the knee amputation, esophageal reflux, persistent mental disorder, and depressive disorder.	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 5	F 242		

An annual minimum data set (MDS) was completed on 8/3/11 and a quarterly MDS was done on 10/27/11. Both MDSs indicated R46 was cognitively intact with no signs or symptoms of delirium, psychosis or any behavioral issues. She had no communication barriers and was generally independent with eating after staff set up her meals.

R46 was again interviewed at 8:09 a.m. on 1/25/12. She was eating her breakfast and reported that she was not satisfied with breakfast served as food was cool. She Indicated that she would talk to dietary staff about this but no dietary staff were available.

R46 was interviewed again at 1:05 p.m. on 1/25/12. Resident was sitting at a table in the dining room with her noon meal in front of her. She was not eating and appeared upset. She reported that she did not like what was served. She indicated the carrots were cold and she did not like the pork patty. Again, she reported she would have told the dietary staff about this and requested an alternative, but no dietary staff was available.

An interview was completed with Dietary Aide (DA)-A, who reported an alternate was available to all residents if they do not like what was served for the main entrée. DA-A indicated the alternate was not posted and so residents do not know what the alternate would be. If a resident voices that they do not like the main entrée, dietary staff will request an alternate from the cook. DA-A reported that soup and sandwiches are always available to residents at their request.

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 6	F 242		

An interview was completed with the Dietary Manager at 12:34 p.m. on 1/25/12. She reported that she was unaware of R56 ' s complaint of not having choices for meals. The DM did report R56 did have problems asserting herself at times and if she was dissatisfied with food served, may not say anything to staff. The DM reported that at the present time, the facility had a fairly passive population, who may not report any concerns they have. The DM did indicate that after the meal was served, dietary staff do not check with residents regarding their meal satisfaction and so she did verify that there would not be any dietary to tell if they did not like what was served.

An interview with registered nurse Clinical Manager (CM) C was completed at 1:15 p.m. on 1/25/12. CM-C reported that R56 had not voiced any complaints regarding not having choices for food or any dissatisfaction regarding food choices. CM-C did indicate that if R56 had any concerns, she would generally talk to her daughters, who would bring the issue to the nursing staff. CM-C reported " R56 does have a hard time voicing concerns. "

R28 was not provided the dietary plan requested by family members.

A telephone interview was completed at 11:25 a.m. on 1/24/12 with R28 ' s family-A, who reported that the family was very concerned regarding R28 ' s weight gain since admission to the facility. Family-A stated that R28 had gained 8 pounds in the recent past and she had talked to the facility ' s Dietary Manager about this. Family -A indicated they had requested R28 not receive any " sugary snacks " but the ' facility does not

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 7 seem to get it ' and continues to provide sugary snacks during snack pass. " Family-A stated she and her sister had requested R28 be given a piece of fruit at snack time. Family-A reported that her mother will eat whatever anyone gives her too eat and even if R28 was full, will eat it until it is gone. R28 had a current diagnosis that included dementia, carcinoma of unspecified part of intestine, abnormality of gait, atrial fibrillation and hypothyroidism. According to the significant change MDS, completed on 12/29/11, R28 had both long and short term memory issues and was severely cognitively impaired. She had problems understanding and making self understood at times. She needed extensive assistance of 2 facility staff for ADLs (activity of daily living) and needed limited assistance of one staff at mealtime. An interview was completed with the Dietary Manager (DM) at 12:34 p.m. on 1/25/12, who reported she was aware that family was very concerned regarding resident ' s weight gain. DM reported that she had negotiated with the family to put resident on " small portions " and since doing this, R28 had " lost a few pounds ". DM indicated she did not feel that it was " right to withhold sugary snacks " from R28 and reported she was under the impression the family was accepting of the small portions to R28 ' s diet and were willing to bypass the ' fruit only for snack ' request. The DM did report that R28 was unable to make personal choices regarding meal choices and ate whatever staff gave her.	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 8 R25 did not receive an opportunity for choice at snack times. During interview at 6:30 p.m. on 1/23/12, R25 stated "I get hungry in between meals. I'd like something that will tide me over - like a half sandwich or something-nothing sweet." At 2:15 p.m. on 1/25/12, R25 indicated she had told nursing staff she gets hungry between meals and she did not like sweets but she hasn't seen anything done about the report yet. R25 had multiple diagnoses including pyelonephritis and malaise/fatigue. The Minimum Data Set (MDS) dated 12/23/11 identified R25 as alert and oriented. An observation of the snack cart at 8:00 p.m. on 1/23/12 revealed cookies as the primary snack with substantial snacks of sandwiches provided to specific residents. The cart also contained juice. When asked at 2:00 p.m. on 1/26/12, Clinical Manager(CM) B indicated R25's request came up in care conference in 12/11. CM-B stated "We told her there's always sandwiches or snacks available, she just has to ask. There's always sandwiches on the cart and I wonder why she (R25) doesn't know that. Sometimes the kitchen has made special snacks for people - they would make one especially for the resident. I don't think we talked about just sending her up something - it just came up briefly." An interview at 9:30 a.m. on 1/26/12 with the Dietary Manager (DM) was completed. The DM reported she was unaware of the R25's request.	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 9 The DM also stated "They (the residents) just need to ask." R67 did not receive an opportunity for choice at meal times. R67 had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11 R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room, according to the Director of Nursing (DON) during an interview at 1:30 p.m. on 1/26/12. At 9:00 a.m. on 1/25/12, R67 received her breakfast tray from staff of scrambled eggs, cereal and yogurt. Staff left room after setting up R67's tray. There was no offer of choice prior to the staff member leaving the room. R67 indicated she was "so tired of eggs". R67 clarified she "will eat a soft egg - like a fried egg - but sick of scrambled eggs. I got them every morning for 5 months at my previous place. That was a nice place - you could choose what you wanted to eat." When asked if she got choices with her meals now, R67 stated "No, not at all. You get what you get." According to Clinical Manager (CM) C at 10:30 a.m. on 1/26/12 , "(R67) is informed at care conferences and resident council to ask for something different if she doesn't like it. There's always second choices-she has asked for something different when she doesn't like it."	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 10 R67 stated at 10:50 a.m. on 1/26/12 "I've been in this room a long time. There's not always someone to tell if I don't like it." R67 further stated she was "not fussy but it would be kind of nice to have some options." R56 was not offered an opportunity for choice at meal times. Upon interview at 10:10 a.m. on 1/24/12, R56 indicated there was no choice for meal selection at meal time. She stated "When I don't like it, you're stuck with it." R56 had multiple diagnoses including Diabetes and Glaucoma. R56 was assessed by staff as alert and oriented with minor forgetfulness according to progress notes. Observation of the lunch meal in the north dining room on 1/25/12 revealed R56 did not eat her meat. There was no staff available in the dining room for residents to ask for an alternate selection. An interview with R56 at 1:50 p.m. on 1/25/12 indicated "I don't care for pork. I thought it was fish. I only had a bite. I didn't care for it. They didn't offer me anything else. I just ate the potatoes. They never ask (if I would like something different)." Interview with the Dietary Manager (DM) at 9:30 a.m. on 1/26/12 indicated "(R56) had never told me she didn't like pork." The DM indicated residents need to indicate they do not like something in order to get something different. When asked how resident's were supposed to report it when there was no staff available in the dining room to tell, the DM stated "Good point -	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 11 there are no staff to tell if they don't like the food served." The DM also indicated that residents can review the posted menu on their way through the door and if they don't like something just let someone know and they will provide a substitute prior to the resident's food being served. When asked how resident's can review the menu if they are unable to visualize the menu or can't read the DM again stated "residents can tell staff they don't like the food being served and they would be offered something else." "We always have leftovers available in the freezer or soup and sandwich available." When interviewed at 2:20 p.m. on 1/26/12, Clinical Manager(CM) B indicated she was unaware R56 was having an issue with choices at meal time. "She's pretty good about making her needs known."	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 12 Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess risk and interventions to minimize the risk for pressure ulcer development and worsening of pressure ulcers for 1 of 3 residents (R113) reviewed for pressure ulcers and related to wheelchair positioning needs for 1 of 3 residents (R93) reviewed in the sample for positioning. Findings include: R113 was admitted on 11/25/11 with a stage I pressure ulcer on his coccyx, which developed into two stage II pressure ulcers 12/18/11 and	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 13 12/20/11. R113 had diagnoses that included urinary retention, fatigue, severely under weight, advanced dementia with depression and anxiety, and a history of infection. The admission minimum data set (MDS) dated 12/2/11, identified R113 was cognitively intact, no behavioral concerns, and required extensive assistance of one staff for repositioning. The MDS indicated R113 was at high risk for pressure ulcer development and did not have one or more unhealed pressure ulcers at a stage I or higher. The MDS revealed skin and ulcer treatments included a pressure reducing device for his chair and bed, a turning and repositioning program, and ointments/medication application to his body (not his feet). The admission initial nursing data form, dated 11/25/11, identified R113 had a reddened coccyx and identified that a tissue tolerance test was to be completed. R113's tissue tolerance observation for the lying position, dated 11/25/11, identified redness on his coccyx after lying for two hours. The observation form then instructed staff to re-observe after one and a half hours. The observation form asked after one hour was the redness noted over the boney prominences which the facility identified as "Yes, the area remained red, initiate wound care protocols stage I and redo the observation at 1 hour." R113's tissue tolerance for sitting observation dated 11/25/12 read "Unable to assess - resident in lying position through-out shift." The facility did not initiate wound care	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 14 protocols for a stage I pressure ulcer to monitor the area and did not assess R113 for tissue tolerance while sitting to determine appropriate interventions for repositioning needs. A tissue tolerance skin risk factor evaluation form, dated 12/1/11, noted R113 was at mild risk for skin breakdown. It identified he had a bio foam mattress and pressure redistribution cushion in his wheelchair. It noted he "has a reddened coccyx which was present upon admit" and to apply barrier cream to this area twice daily. On 12/18/11, a weekly wound documentation form was initiated for a stage II pressure ulcer on R113's coccyx. The form indicated R113 had a stage II pressure ulcer on his coccyx measuring 1.5 cm by 1.5 cm by 0.2 cm, with no draining or odor. The treatment included an Allevyn foam dressing and Tena with Zinc. On 12/23/11 the wound was noted to be stable, and was reassessed as a stage II pressure ulcer measuring 0.2 cm by 0.1 cm by 0.1 cm, with the same treatment. On 12/30/11 the wound was noted to be improving, and was reassessed as a stage II pressure are measuring 0.4 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/8/12 the wound was noted as stable and was reassessed as a stage II pressure are measuring 0.6 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/17/12 the area was assessed by the wound care practitioner. On 12/20/11 a weekly wound documentation form was initiated for a stage II pressure ulcer identified on the diagram as located on the lower area of the buttock and noted as a "lower open area." The form indicated R113 had a stage II	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 15 pressure ulcer on his lower buttock measuring 1.8 cm by 1.2 cm by 0.1 cm, with no draining or odor. The treatment included an Duoderm dressing. On 12/25/11 the wound was reassessed as a stage II pressure ulcer measuring 0.2 cm by 1.5 cm with no depth with 100% granulation. At this time an Allevyn foam dressing and Tena with Zinc treatment was applied and the area was noted as improved. On 1/24/12 the wound was reassessed as a stage II pressure area measuring 0.3 cm by 0.2 cm with no depth, the area was noted as dry, the treatment was changed to Mepilex Boarder and was identified as improved. On 1/17/12 the area was assessed by the wound care practitioner. No further documentation was provided to indicate that the area was monitored or assessed from 12/25/11 to 1/17/12. The physician orders and progress notes form dated 1/17/12 identified a wound care consult was completed. The note indicted R113 had stage II skin breakdown on his sacrocoxygeal area for approximately two weeks. The note identified R113 was very thin in stature with a weight of 120 pounds on admit, with an approximate eight to ten pound weight loss since then. It noted R113 laid down after breakfast and lunch, used a wheelchair for locomotion, had a foam cushion, and did not elevate the head of his bed. It identified R113 was turned every two hours but turns self back to supine and has an alternating air mattress. The note indicated on exam the coccyx ulcer measured 0.5 cm by 0.5 cm and the right sacral ulcer measured 2 cm x 1 cm; both stage II with scant exudates. The practitioner instructed to continue with the alternate air mattress overlay, lay down every two	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 16 hours twice a day, try to alternate sides, and apply Mepilex Boarder four by four dressing to coccyx ulcer in a diamond shape, change every other day. Wound care was completed on 1/25/12 and was not due until 1/27/12. At 9:45 a.m. on 1/26/12 this surveyor requested to observe R113 wound and dressing change. Wound care for R 113 was observed at 10:12 a.m. on 1/26/11 and the Mepilex Boarder dressing was not applied to wound. Nursing assistant (NA)-A verified the dressing came off that morning during morning cares. NA-A confirmed she reported that information to registered nurse (RN)-A. R113 was observed to be very thin and his coccyx protruded. The wound was approximately 0.3 by 0.2 with superficial depth. The surrounding skin appeared red and dry. CM-A reported the area was not warm to the touch and confirmed the area had some dry, flaking skin. CM-A applied a Zinc ointment and a Mepilex Boarder dressing to the area in the shape of a diamond. During interview at 10:32 a.m. on 1/26/11, RN-B stated she took over for RN-A at 9:30 a.m. and it was not passed on in report that R113's dressing came off during morning cares. During interview at 10:34 a.m. on 1/26/12 clinical manager (CM)-B verified the dressing should have been re-applied if it had fallen off. CM-B stated she expected that information to be passed on in report. CM-B verified the tissue tolerance was not completed and and should have been to determine appropriate timely repositioning intervention. CM-B confirmed the the tracking of the wounds were to be done	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 17 weekly and that this was not completed for each identified pressure area. CM-B verified during the dressing change the surround area where the Zinc ointment and Mepilex Boarder dressing was applied was dry and verified that these treatments were intended to dry out moist wounds. CM-B stated the wound appeared drier than when she last applied the treatment but did not find this concerning enough to consult with the practitioner to readdress if the current treatment was appropriate to promote healing of the wound. During follow-up interview at 10:48 a.m. on 1/26/12 NA-A stated the staff were expected to place a pillow behind R113's back when repositioning him side to side. NA-A stated R113 frequently moved himself back onto his back. During interview at 11:03 a.m. on 1/26/12, NA-D stated it was not her practice to place a pillow behind R113's back when turning him side to side. The Pressure Ulcer Risk Policy dated 9/11 indicated regardless of the residents total risk score each risk factor and potential causes should be reviewed individually. It instructed to implement interventions according to the Braden score and/or residents individual risk factors identified. Wheelchair assessment R93 had multiple diagnoses including cerebral vascular accident (CVA). R93 was assessed by facility staff to be alert and	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 18 oriented according to the most recent care conference review, dated 12/8/11. A review of the MDS (Minimum Data Set) and CAA (Care Area Assessment) dated 6/16/11, revealed no assessment for wheelchair positioning. Review of all assessments completed since 6/11 revealed no assessments were completed for wheelchair positioning. Review of the quarterly care conference documentation dated 12/8/11, 9/14/11, and 6/23/11 revealed wheelchair positioning had never been addressed. On 1/23/12 at 7:30 p.m. and 1/25/12 at 8:00 a.m., R93 was observed to be slouched forward in the wheelchair. Observation on 1/25/12 at 2:00 p.m. revealed only minor changes in his positioning in the wheelchair. When asked, R93 was unable to position himself correctly in the w/c. At that time R93 was asked about his comfort level in the wheelchair. He stated "It's not the best in the west." R93 continued to say it would be better if he could "sit up a little bit better." Review of R93's record revealed no progress notes from therapy or nursing identifying the problem of wheelchair positioning. Interview with Clinical Manager-B (CM-B) indicated she was aware of his positioning issues with the wheelchair. "(R93) has always been a sloucher. I assumed he was comfortable. He never said anything to me." CM-B admitted she had never asked R93 about his wheelchair, but "I'll talk to him about it."	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 19 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record observation, interview and document review, the facility failed to develop a comprehensive care plan related to contact precautions for 1 of 1 residents (R67) in the sample reviewed for infection control protocols. Findings include: R67 did not have a comprehensive care plan related to infection control precautions. R67 had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11, R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that	F 279		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 20	F 279		

causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room since this date, according to the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12.

During observations of care at 8:00 a.m. on 1/25/12, R67 was observed in a private room. Nursing assistant (NA)-A was observed to gown and glove prior to entering the room and indicated R67 was in isolation due to a c-diff infection.

Review of the care plan identified the problem of R67's c-diff infection. The problem was initiated 1/11/12. The goal was for the resident to have no complications related to the infection. The care plan identified multiple interventions including to monitor the resident, education and disinfecting equipment used before it leaves the room. The care plan failed to identify the contact precautions, if the resident could leave the room and if so what needed to be done prior to the resident leaving the room, at what point the isolation precautions could be lifted, and what psychosocial things were going to be done while R67 was required to stay in her room.

Clinical Manager (CM)-C stated at 10:20 a.m. on 1/26/12, the DON wrote R67's care plan. At 10:50 a.m. on 1/26/12 the DON stated "This was new to us [treating C-diff} so we're really working hard to get it right." After review of the assessment of R67's progress at 1:30 p.m. on 1/26/12, she stated "I guess I didn't add it to the actual care plan. I believe it was included [contact precautions] on the aide sheet." When the aide

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 21 sheet was reviewed together, it failed to identify contact precautions but did identify the c-diff Infection.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident's plan of care was revised as appropriate related to fall risk for 1 of 3 residents (R56) reviewed in the sample for accidents and related to an unavoidable sensory decline in vision for 1 of 1 residents (R56) reviewed in the sample for sensory problems.	F 280		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22 Findings include: R56 did not have her care plan revised to minimize the risk of further falls following a fall. In addition, the care plan was not revised according to R56's current visual limitations or to assist with maintaining or improving her independence as it related to a decline in vision. R56 had multiple diagnoses including transient ischemic attacks (TIA's), glaucoma and diabetes. An annual minimum data set (MDS) completed on 8/3/11 and the quarterly MDS completed on 10/26/11, indicated R56 was cognitively intact with no signs or symptoms of psychosis. R56 also had no behavioral issues. The MDSs noted R56 had visual impairments but was able to read large print and was able to feed herself meals after the staff "set up" the meal. The MDSs also indicated that R56 had no history of falls. According to progress notes from 8/23/11 through 1/25/12, R56 is alert and oriented with minor forgetfulness. The forgetfulness increased with urinary tract infections (UTI's). R56 had a fall from bed at 1:45 a.m. on 1/20/12. According to the incident report and progress note from the fall, R56 stated she fell while trying to get up to go to the bathroom. R56 was being actively treated for a UTI at the time of the fall. Although R56 fell on 1/20/12, there were no interventions put in place to minimize the risk of further falls until 1/24/12.	F 280		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23 In the area of the incident report directing staff to document immediate interventions implemented, a low bed was identified by the LPN completing the report. However, R56 was already in a low bed at the time of the fall. When asked about the delay in interventions at 3:15 p.m. on 1/24/12, Clinical Manager (CM) B indicated she received the report on 1/23/12. After review, she had further investigation to do before bringing it to the interdisciplinary team (IDTeam) for review. On 1/24/12 CM-B was able to bring the incident report forward to the IDTeam. At that time the team decided to implement a sensor pad alarm which would trigger the call light should R56 attempt to get up from bed independently. CM-B verified the above findings were accurate. When asked what was expected of the floor nurses when the incident occurred, CM-B indicated that the incident should be reviewed by the nurse with appropriate interventions implemented at the time of the incident. CM-B confirmed that the low bed was already in place at the time of the incident. Although a Fall Risk Evaluation had been completed on 1/24/12, it failed to identify R56's significant visual limitations and her acute UTI at the time of the fall. R56 was interviewed at 10:10 a.m. on 1/24/12. She indicated her vision had significantly declined in "the past few months." She further reported that at her last ophthalmology appointment "they (the physician) call me legally blind." R56 further stated she "used to" be able to make out the headlines and pictures in the newspaper, but she can no longer do that unless the headlines are	F 280		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 24 "really big." R56 stated "They don't give me a lot of help at meals. I have a hard time feeding myself - getting the food on the fork and getting it to my mouth.' On 1/25/ 12 at 1:30 p.m. Nursing Assistant (NA) C indicated he was aware of R56's visual limitations. He stated "I ask her how she's doing and she always talks about - I'm losing my vision - I can't see that kind of thing." When interviewed at 1:15 p.m. on 1/26/12, Clinical Manager (CM) B indicated she was unaware R56 had significant limitations in her vision. She reported the first time she was aware of the limitation was "yesterday in care conference." She further indicated that after discussion at the care conference, "dietary is going to get her a dark plate so she can see her food better. Part of what we talked about yesterday was to have dietary (staff) explain food and use clock method when the food is provided to her." The current plan of care identified visual limitations on 8/18/11. The goal was to maintain her ability to read large print through the review date of 2/2/12. R56 was no longer able to read most headlines in the newspaper. Further, according to the interview on 1/24/12 at 10:10 a.m. R56 struggled to eat independently, could no longer see to pick out her clothing and could make out large objects within her environment but was unable to determine what those objects were in most cases. R56's care plan failed to be revised with appropriate interventions to assist with the identified decline in vision.	F 280		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	Continued From page 25 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure each resident received the necessary care and services related to wheelchair positioning for 1 of 3 residents (R93) reviewed in the sample for positioning. Findings include: R93 did not receive assistance with the identified problem of wheelchair positioning. R93 had multiple diagnoses including cerebral Vascular Accident (CVA). R93 was assessed by facility staff to be alert and oriented according to the most recent care conference review, dated 12/8/11. Although R93 has been seen by Occupational Therapy in the past, R93 had never been seen by therapy for wheelchair positioning. At 7:30 p.m. on 1/23/12 and 8:00 a.m. on 1/25/12, R93 was observed to be slouched forward with pelvis pushed forward in wheelchair and a large gap between his back and the back of the wheelchair. In addition his pelvis was somewhat twisted in the chair with his left hip tight against	F 309		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 26 the side of the wheelchair. Upon request at 7:30 p.m. on 1/23/12, R93 could independently adjust himself in the wheelchair, however he was unable to get his pelvis back and centered in the wheelchair. An interview with R93 was completed at 8:00 a.m. on 1/25/12 and was asked about his comfort level in the wheelchair. He stated "It's not the best in the west." R93 continued to report "it would be better if he could sit up a little bit better". When asked what he would like done differently about his wheelchair, he commented he thought a "little bigger chair" would be helpful. R93 indicated he would be receptive to assistance with wheelchair positioning as it would be "a little easier to sit in all day." Review of R93's record revealed no progress notes from therapy or nursing identifying the problem of wheelchair positioning. Interview with Clinical Manager (CM)-B indicated she was aware of his positioning issues with the wheelchair. "(R93) has always been a sloucher. I assumed he was comfortable. He never said anything to me." CM-B admitted she had never asked R93 about his wheelchair, but "I'll talk to him about it."	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 27 by: Based on observation, interview and document review, the facility failed to ensure each resident was provided with appropriate treatment and services to maintain or improve their abilities related to an unavoidable sensory decline in vision for 1 of 1 residents (R56) reviewed in the sample for sensory problems. Findings include: R56 had a significant decline in vision without intervention. R56 had multiple diagnoses including glaucoma, diabetes, and diabetic retinopathy. The care area assessment (CAA) for vision, dated 8/17/11, indicated R56 had impaired vision due to difficulty reading regular print but was able to read large print and see objects in the environment. The assessment failed to include the diagnoses of glaucoma, history of cataracts or transient ischemic attack (TIA), both of which could contribute to a visual decline. The most current nutrition assessment completed 11/2/11, identified R56 as sighted with no problems feeding self. The current care plan, revised 11/11, identified impaired vision. The established goal was to maintain the ability to read large print. The approaches included "Monitor/document/report to MD the following signs/symptoms of acute eye problems: Change inability to perform ADL's (Activities of Daily Living), decline in mobility, sudden visual loss, pupils dilated, gray, or milky,	F 311		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 28	F 311		

complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision." The care plan did not identify any assistive devices for improving her vision or assisting R56 to maintain her independence.

R56 had ophthalmology visits on 5/17/11 and 11/17/11. She was identified with open angle glaucoma in both eyes and pseudophakia in both eyes. The physician noted the onset to be gradual and no change in treatment was recommended.

R56 was interviewed at 10:10 a.m. on 1/24/11, her vision had significantly declined in "the past few months." She further indicated that at her last ophthalmology appointment "they [physician]call me legally blind." She reported to" be able to make out the headlines and pictures in the newspaper, but she can no longer do that unless the headlines are "really big." R56 stated "They [facility staff] don't give me a lot of help at meals. I have a hard time feeding myself - getting the food on the fork and getting it to my mouth.' When asked if she's talked with therapy about her problems maintaining independence at meals or if any adaptive equipment had been offered, R56 stated "No, they've never given me anything like that."

During an interview at 1:50 p.m. on 1/25/12 , R56 verbalized that wanted to make certain staff understood she wanted to remain as independent as possible and stated "I like to be independent. I just really want to do things for myself as much as I can. I don't want everyone to know I can't see. The aides know - they pick out my clothes for me in the morning."

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 29 On 1/25/ 12 at 1:30 p.m., nursing assistant (NA) -C indicated he was aware of her visual limitations. He stated "I ask her how she's doing and she always talks about losing her vision" and that she "can't see" When interviewed at 1:15 p.m. on 1/26/12, Clinical Manager (CM)-B indicated she was unaware R56 had significant limitations in her vision. She indicated the first time she was aware of it was "yesterday in care conference." She further indicated that after discussion "Dietary is going to get her a dark plate so she can see her food better. I should make her an eye appointment to get her vision checked. I wasn't aware her sight was that bad. Her last ophthalmology appointment was 11/17/11 - there was nothing specific about visual ability. Part of what we talked about yesterday was to have dietary explain food and use clock method when the food is provided to her."	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 314		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 30 review the facility failed to monitor and provide treatment to minimize the risk and promote healing of pressure ulcers for 1 of 3 residents (R113) reviewed for pressure ulcers. Findings include: R113 was admitted on 11/25/11 with a stage I pressure ulcer on his coccyx which developed into two stage II pressure ulcers on12/18/11 and 12/20/11. R113 had diagnoses that included urinary retention, fatigue, severely under weight, advanced dementia with depression and anxiety, and a history of infection. The admission minimum data set (MDS) dated 12/2/11 identified R113 had no cognitive impairments, no behaviors, and required extensive assistance of one staff for repositioning. The MDS indicated R113 was at high risk for pressure ulcer development and did not have one or more unhealed pressure ulcers at a stage I or higher. The MDS revealed skin and ulcer treatments included a pressure reducing device for his chair and bed, a turning and repositioning program, and application of ointments/medication other than to his feet. The admission initial nursing data form dated 11/25/11 identified R113 had a reddened coccyx and a tissue tolerance was to be completed. R113's tissue tolerance observation for the lying position dated 11/25/11 identified staff observed his current skin integrity after two hours and redness was noted on his coccyx. The	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 31 observation form then instructed staff to re-observe after one and a half hours. The observation form asked after one hour was the redness noted over the boy prominence's which the facility identified as "Yes, the area remained red, initiate wound care protocols stage I and redo the observation at 1 hour." R113's tissue tolerance for sitting observation dated 11/25/12 read "Unable to assess - resident in lying positioning through-out shift." The facility did not initiate wound care protocols for a stage I pressure ulcer to monitor the area and did not assess R113 for tissue tolerance while sitting to determine appropriate interventions for repositioning needs. A tissue tolerance skin risk factor evaluation form dated 12/1/11 noted R113 was at mild risk for skin breakdown. It identified he had a bio foam mattress and pressure redistribution cushion in wheelchair. It noted he "has a reddened coccyx which was present upon admit" and to apply barrier cream to this area twice daily. R113's plan of care, dated 12/13/11, identified he had a stage I pressure ulcer on his coccyx related to immobility and low body weight. The interventions included the application of barrier cream to his coccyx and that he was turned and repositioned throughout the day and repositioned during routine rounds on the night shift. It also identified he was to utilize a biofoam mattress and pressure redistribution cushion in his wheelchair. On 12/18/12 the care plan was updated to include an air mattress overly to the bed. On 12/18/11, a weekly wound documentation	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 32	F 314		

form was initiated for a stage II pressure ulcer on R113's coccyx. The form indicated R113 had a stage II pressure ulcer on his coccyx measuring 1.5 cm by 1.5 cm by 0.2 cm, with no draining or odor. The treatment included an Allevyn foam dressing and Tena with Zinc. On 12/23/11 the wound was noted to be stable, and was reassessed as a stage II pressure ulcer measuring 0.2 cm by 0.1 cm by 0.1 cm, with the same treatment. On 12/30/11 the wound was noted to be improving, and was reassessed as a stage II pressure are measuring 0.4 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/8/12 the wound was noted as stable and was reassessed as a stage II pressure are measuring 0.6 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/17/12 the area was assessed by the wound care practitioner.

On 12/20/11, a weekly wound documentation form was initiated for a stage II pressure ulcer identified on the diagram as located on the lower area of the buttock and noted as a "lower open area." The form indicated R113 had a stage II pressure ulcer on his lower buttock measuring 1.8 cm by 1.2 cm by 0.1 cm, with no draining or odor. The treatment included an Duoderm dressing. On 12/25/11 the wound was reassessed as a stage II pressure ulcer measuring 0.2 cm by 1.5 cm with no depth with 100% granulation. At this time an Allevyn foam dressing and Tena with Zinc treatment was applied and the area was noted as improved. On 1/24/12 the wound was reassessed as a stage II pressure area measuring 0.3 cm by 0.2 cm with no depth, the area was noted as dry, the treatment was changed to Mepilex Boarder and was identified as improved. On 1/17/12 the area

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 33 was assessed by the wound care practitioner. No further documentation was provided to indicate that the area was monitored or assessed from 12/25/11 to 1/17/12. The physician orders and progress notes form dated 1/17/12 identified a wound care consult was completed. The note indicted R113 had stage II skin breakdown on his sacrocoxygeal area for approximately two weeks. The note identified R113 was very thin in stature with a weight of 120 pounds on admit, with an approximate eight to ten pound weight loss since then. It noted R113 laid down after breakfast and lunch, used a wheelchair for locomotion, had a foam cushion, and did not elevate the head of his bed. It identified R113 was turned every two hours but turns self back to supine and has an alternating air mattress. The note indicated on exam the coccyx ulcer measured 0.5 cm by 0.5 cm and the right sacral ulcer measured 2 cm x 1 cm; both stage II with scant exudates. The practitioner instructed staff to continue with the alternate air mattress overlay, lay down every two hours twice a day, try to alternate sides, and apply Mepilex Boarder four by four dressing to coccyx ulcer in a diamond shape, and to change this dressing every other day. Wound care was completed on 1/25/12 and was not due until 1/27/12. At 9:45 a.m. on 1/26/12, this surveyor requested to observe R113 wound and dressing change. Wound care for R113 was observed at 10:12 a.m. on 1/26/11 and the Mepilex Boarder dressing was not applied to wound. Nursing assistant (NA)-A verified the dressing came off that morning during morning cares. NA-A confirmed she reported that	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34 information to registered nurse (RN)-A. R113 was observed to be very thin and his coccyx protruded while his buttock tissue appeared to sag and sink in giving the appearance of no buttock. The wound was approximately 0.3 by 0.2 with superficial depth. The surrounding skin appeared red and dry. CM-A reported the area was not warm to the touch and confirmed the area had some dry, flaking skin. CM-A applied a Zinc ointment and a Mepilex Boarder dressing to the area in the shape of a diamond. During interview at 10:32 a.m. on 1/26/11 RN-B stated she took over for RN-A at 9:30 a.m. and it was not passed on in report that R113's dressing came off during morning cares. During interview at 10:34 a.m. on 1/26/12, clinical manager (CM)-B verified the dressing should have been re-applied if it had fallen off. CM-B stated she expected that information to be passed on in report. CM-B verified the tissue tolerance was not completed and should have been used to determine appropriate timely repositioning intervention. CM-B confirmed the tracking of the wounds were to be done weekly and this, was not completed for each identified pressure area. CM-B verified during the dressing change, the surrounding area where the Zinc ointment and Mepilex Boarder dressing was applied was dry and verified that these treatments were intended to dry out moist wounds. CM-B stated the wound appeared drier then when she last applied the treatment but did not find this concerning enough to consult with the practitioner to readdress if the current treatment was appropriate to promote healing of the wound.	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35 During follow-up interview at 10:48 a.m. on 1/26/12, NA-A stated the staff were expected to place a pillow behind R 113's back when repositioning him side to side. NA-A stated R113 frequently moved himself back onto his back. During interview at 11:03 a.m. on 1/26/12 NA-D stated it was not her practice to place a pillow behind R113's back when turning him side to side. The Pressure Ulcer Risk Policy, dated 9/11, indicated regardless of the residents total risk score each risk factor and potential causes should be reviewed individually. The policy also instructed staff to implement interventions according to the Braden score and/or resident's individual risk factors that were identified.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely interventions to minimize the risk of falls for 1 of 3 residents (R56) reviewed in the sample for accidents.	F 323		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 36 Findings include: R56 had a fall which was not reviewed in order to ensure adequate safety interventions for 4 days. R56 had multiple diagnoses including transient ischemic attacks (TIA's), glaucoma, and was currently being treated for a urinary tract infection (UTI). According to consistent daily progress notes, R56 was assessed by the facility to be alert and oriented with forgetfulness which was worse when R56 had a UTI. The Fall Risk Evaluation completed 8/3/11, identified R56 to be at low risk for falls. The evaluation identified "will self transfer at times, forgetful, doesn't know limitations, extensive assist with transfers, doesn't always remember to use call light, raised edge mattress in place." The care plan initiated 8/18/11, identified limited physical mobility with a goal to "remain free from falls through the review date." The goal had been reviewed with an updated review date of 2/2/12. The care plan contained multiple interventions to maintain mobility and the safety interventions were "Raised edge mattress in place to orient her to bed parameters. Keep bed in lowest position to prevent injury. Reminder sign in place to remind (R56) to use call light and wait for assist. Provide verbal reminders of call light use with each application." R56 had a fall on 1/20/12 at 1:45 a.m. According to the incident report and progress notes for this date and time, R56 was attempting to get up and	F 323		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 37 go to the bathroom. R56 got up from the window side of the bed and was found sitting on buttocks by bed. R56 normally gets up from bed on the side nearest the bathroom. The call light was within reach but was not used. In the section for immediate interventions following the fall, the completing LPN indicated "low bed" which was already in place at the time of the fall. This fall was not reviewed by the interdisciplinary team with interventions implemented until 1/24/12. According to Clinical Manager(CM)-B at 3:15 p.m. on 1/24/12, "Whoever the floor nurse is fills out the incident report and notifies family and physician. Then the incident reports go to the nurse manager and we discuss it in morning meetings, figure out interventions or we further investigate. Thursdays are the safety meeting. Therapy is not always at safety meeting but can call them and have them come down for a specific resident. We review all falls and interventions we put in place. If interventions are effective we close the incident report. If they're not effective or we have more to do, we leave the report open and continue to re-evaluate until we feel we came to a good solution." With regard to falls on Friday night or over the weekend, CM-B indicated "The nurse managers are on call but if there's nothing alarming, we review it Monday morning. We try and check in on the week end. They usually call us but sometimes they don't, so we call and check in and we may review it then." When asked why this fall waited for 4 days to be reviewed and have interventions put in place for safety, CM-B indicated that she had some questions regarding the fall and had to investigate on 1/23/12. She further stated that once her investigation was completed, she was able to	F 323		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 38 review it with the interdisciplinary team on 1/24/12. CM-B indicated "We're going to put a bed sensor pad on her bed which will trigger her call light if she gets up. (R56) is a little more forgetful - she got up on window side of the bed instead of the door side. In this case it did wait until Tuesday for intervention because it took me awhile to finish up the investigation." CM-B verified that R56 is " a little more confused" at night. The Fall Risk Evaluation dated 1/24/12, after the fall, identified R56 remained a low risk for falls. It should be noted that R56 was being treated for a UTI at the time of the fall, which was not included in the evaluation. Further, the evaluation failed to include R56's significant visual limitations - indicating only that her vision was "impaired - sees large print, but not regular print in newspapers/books." The bed sensor was observed to be added to R56's bed on 1/24/12 and had been added to the care plan. However, the care sheet utilized by the nursing assistants failed to include the addition of the sensory pad to the bed. During an interview with R56 at 10:25 a.m. on 1/24/12, R56 indicated she "forgot" to use the call light the night of the fall. She further indicated she's been having problems with incontinence, but the problem is improving since working with therapy on it. She further stated "when you gotta go, you gotta go" and she just wanted to get to the bathroom. "I hate to wet myself."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 39 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received appropriate monitoring of medication for 1 of 10 resident (R91) in the sample reviewed for unnecessary medications. Findings include: An observation of medication administration at 12:25 p.m. on 1/25/12 revealed 91's pulse was not taken prior to the administration of Lanoxin	F 329		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 40 (Digoxin-a cardiac medication) as ordered by her physician. R91 had multiple diagnoses including atrial fibrillation. She had a physician's order for Lanoxin (digoxin) 0.25 mg by mouth every day and according to the facility's standing orders, which were also signed by her physician, staff were directed to not give this medication if R91's pulse was less than 55 beats per minute. A review of the medication administration records (MAR's) revealed there was no pulse documented for the months of November, 2011, December, 2011 and January, 2012 There was also no information on the MAR directing the facility staff to hold the digoxin for a pulse less than 55 or a prompt to take the pulse prior to administration. Interview with registered nurse (RN)-C at 8:15 a.m. on 1/26/12 revealed "I don't know why we don't take her pulse anymore. I'm thinking we used to but we don't do it anymore - but I don't know why. It's fallen off for a few residents where we used to do it and now we don't anymore." Clinical Manager (CM)-B at 8:30 a.m. on 1/26/12 verified the physician orders were accurate and the pulse should have been taken prior to administration of the digoxin.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 41 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to store food service equipment in a sanitary manner to prevent the transmission of food bourne illness and physical contamination to food, having the potential to affect 70 of 70 residents who ate at the facility. Findings include: During the initial kitchen observation at 1:33 p.m. on 1/23/12, the Hobart meat slicer was stored on the counter top covered and was considered clean. The meat slicer had an accumulate of food residue on the blade rotator and sharpener component, which was an area in which food came in contact with when slicing. The stove hood vents, situated above the grill and open cooking range, were soiled with a brown/black substance and thick layer of dust build up. An Edmund industrialized sized can opener was attached to the end of the steam table area. The can opener blade was dull and had metal chard's behind the blade. Dietary manger (DM) confirmed these observations. During interview at 1:42 p.m. on 1/23/12, Cook-A confirmed the meat slicer was last used	F 371		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 42 yesterday for slicing roast beef. Cook-A demonstrated how to take apart the meat slicer for cleaning. Cook-A stated she was unaware the sharpener component, the area in which had an accumulate of food residue, was removable for cleaning and sanitizing. During interview at 1:44 p.m. on 1/23/12, DM stated staff were to take apart the meat slicer after every use, clean and sanitize the machine and send the detachable components through the dishwasher, including the sharpener component. DM reported she was unsure the last time the blade was changed on the industrial sized can opener because it was rarely used but confirmed staff used it on occasion. During a follow-up observation at 7:32 a.m. on 1/25/12, Cook-B was asked to disassemble the meat slicer, which was covered and considered clean. Cook-B detached the sharpener competent. The blade rotator situated under the sharpener component had a build up of food residue. Cook-B confirmed the observation and without cleaning or sanitizing the machine, reassembled the machine and covered it for the next use. Cook-B reported the meat slicer was used one to two times a week to slice meats. During a follow-up observation at 1:35 p.m. on 1/26/12, DM was asked to disassemble the meat slicer, which was covered and considered clean. DM detached the sharpener competent. The blade rotator situated under the sharpener component had a build up of food residue. DM stated she asked staff to clean and sanitize the machine after the first observation on 1/23/12 but did not follow-up to monitor if the task was done	F 371		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 43 appropriately. DM verified the stove hood vents had not been cleaned and still contained brown/black substance and thick layer of dust build up. DM stated she did not have the vents cleaned because "they were just cleaned on the fourth." DM further stated if she observed something that was soiled or dirty it would be cleaned. DM stated the stove hood vents should have been cleaned after the initial observation and may need to be cleaned more frequently to prevent dust build up. The Hobart meat slicer instructions for cleaning dated 2/01, identified the meat slicer had a top knife cover (sharpener component) that contained the meat slicer sharpener. The instructions indicated the meat slicer machine must be thoroughly cleaned and sanitized after each day's operation or after being idle for an extended period of time. It instructed to remove the sharpener and top knife cover. It identified the top knife cover, deflector and the sharpener housing unit (also part of the sharpener component) needed to be wiped out with no residue remaining inside the sharpener housing unit and on the blade and clean the sharpener in a sink. It instructed to rinse with fresh water and to not wash the slicer components in the dishwasher. R42 obtained ice for ice water from the large ice machine in the North Dining Room without practicing good infection control technique, potentially contaminating the ice machine. At 1:00 p.m. on 1/25/12, R42 entered the dining room to get ice for water. She took the scoop out of the bin and set it on the counter. R42 walked to the sink and dumped part of water from the	F 371		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 44 pitcher. R42 went back to the ice machine with the pitcher. Holding the water pitcher inside of ice machine, R42 used the public scoop to place ice inside of her pitcher coming in contact with pitcher. R42 packed the ice down with the scoop and added more ice again coming in contact with the pitcher. R42 placed the scoop in the ice machine while she set the pitcher down on her walker. R42 then returned the scoop to the plastic bin for ongoing use. At that time R42 verified the pitcher was hers that she had been using the pitcher "since yesterday. I get my own ice water every day. The staff is just so busy." Although there were 4 staff members in the dining room at the time of this incident, no staff intervened with the practice. Nursing Assistant (NA)-C at 1:30 p.m. on 1/25/12 stated "I saw her come in and get her ice. She's really clean. As long as they (residents) wash their hands and stuff, it hasn't been a problem. She's a really clean person. She always gets her own (ice). I've never noticed it to be a problem." When the observation was described to the Infection Control Nurse and the Director of Nursing (DON) at 12:45 p.m. on 1/26/12, the DON stated she would work on this issue as it was "not my first choice" for practice.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 45 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that each resident's medication regimen was free of irregularities related to the administration of Lanoxin (digoxin, a cardiac medication) without regular monitoring of the pulse for 1 of 10 residents (R91) reviewed in the sample for unnecessary medications. Findings include: R91 did not have the irregularity of digoxin administration without the monitoring of pulse identified by the monthly pharmacist's drug review. R91 had multiple diagnoses including atrial fibrillation. R91 had a Physician's order for Lanoxin (digoxin) 0.25 mg by mouth every day. The order dated back to admission on 6/6/11. R91 was admitted with facility standing orders which included an order to hold the administration of digoxin if pulse less than 55. Review of the medication administration records (MAR's) revealed there was no pulse documented for the months of 11/11, 12/11, or 1/12. There was also no information on the MAR directing the facility staff to hold the digoxin for a pulse less than 55 or a prompt to take the pulse prior to administration. Interview with RN-C on 1/26/12 at 8:15 a.m.	F 428		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 46 revealed "I don't know why we don't take her pulse anymore. I'm thinking we used to but we don't do it anymore - but I don't know why. It's fallen off for a few residents where we used to do it and now we don't anymore." Clinical Manager-B (CM-B) on 1/26/12 at 8:30 a.m. indicated she had no additional information and verified the orders were accurate and the pulse should have been taken prior to administration of the digoxin. Review of the monthly pharmacy reviews for medication irregularities revealed no issues identified with the administration of the digoxin for the months of 11/11, 12/11, or 1/12. When the November review was completed, the resident was in the hospital. Per the consulting pharmacist on 1/26/12 at 3:15 p.m. he verified the pulse should have been checked prior to administering the digoxin.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 47 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement and maintain an infection control program to help prevent the development and transmission of infections, failure to follow the recommendations for hand hygiene, appropriate implementation of contact precautions, and proper sanitation of cleaning equipment. This deficient practice had the potential to effect all 70 residents who resided in the facility. Findings include: Although R67 was in contact precautions, staff did not consistently utilize the contact precautions	F 441		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 48 appropriately as directed by facility policy. R67 did not have a comprehensive care plan related to infection control precautions. R67 was admitted to the facility on 11/2/11. She had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11, R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room according to the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12. At 9:05 a.m. on 1/25/12, R67 was served her breakfast tray. Nursing Assistant (NA)-A entered the room without donning personal protective equipment (PPE). NA-A set up R67's tray, placed it on the over-bed table, touching the table with her hands and brushing against it with her uniform. NA-A then assisted R67 to wash her hands, placed sanitizing gel in her own hands and applied the gel onto R67's hands, assisted resident to wash her hands prior to eating. NA-A placed the spoon in R67's hand. NA-A then left R67's room, utilizing sanitizing gel to her own hands. NA-A left the room to get a clothing protector and straws. NA-A again entered the room with no PPE, placed straws in R67's drinks and placed the clothing protector around R67 coming in contact with R67 and the wheelchair with her hands and uniform. NA-A left the room again, this time without washing her hands. She went to the food tray cart, which was stationed in the hallway by R67's room, to obtain jelly from a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49 public bowl of jelly on top of the cart. NA-A returned to the room with the jelly without washing hands or donning PPE. She then finished setting up the breakfast tray for R67. NA-A did not wash hands upon leaving the room. An interview with NA-A at 9:20 am on 1/25/12, indicated she was told "only have to gown/glove when coming body to body contact." She clarified that touching items in the environment wouldn't have been a concern. It's "only if you touch the resident." When asked specifically about touching the resident's hands to wash them and her body to place the clothing protector NA-A stated "Oh yeah you're right I should have put on gloves." NA-A was asked about when to wear a gown and she reported she didn't need to wear one. "Only when doing cares and body to body contact." At 9:35 a.m. on 1/25/12, clinical manager (CM)-A stated "Staff should gown and glove when in direct contact with the resident - although the hands I'm thinking maybe it's not an issue." Explained to CM-A that NA-A washed the residents hands and brushed up against w/c and tray table. CM-A stated "I will check with (the Infection Control Nurse) to be sure what our policy is. She should be washing her hands when she comes into the room and when she leaves the room - foam in foam out." When asked what should be done with the food cart, specifically the bowl of jelly that was potentially contaminated by the infection control breach, CM-A stated "I'm not sure what we would do with the jelly. I will check with (the infection control nurse) and let you know." At 9:50 CM-A returned and verified NA-A should have gowned and gloved if she's brushing up against the resident and wheelchair and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 50 touching the resident. When asked what was going to be done with the food cart and the jelly CM-A stated "We should throw away the jelly and wash the bowl obviously." When informed the cart and the jelly remained in the hall for use, CM-A stated "Oh, I'll go get rid of it right now and we'll talk to (NA-A). Interview with the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12 verified this incident was a breach in their infection control practice. They further indicated NA-A had been re-educated and they would re-educate other staff as well on the infection control protocols including contact precautions. The facility policy "Contact Precautions" dated 1/08 and provided by the DON as current indicated "Gloves should be worn when entering the room and while providing care for a resident." The policy further directed staff to wash their hands after glove removal and "hands should not touch potentially contaminated environmental surfaces or items." The policy indicated gowns should be worn "if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the room." The policy did not identify the term "substantial". According to the DON at 12:45 p.m. on 1/26/12, she would consider substantial to be if the staff member was going to physically come in contact with the resident or the environment. Although the policy identified "Patient Transport" there was no definition of when a resident may come out of their room or what precautions needed to be taken to do so. Hand hygiene was not completed after handling a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 51 soiled dressing, removing gloves and proceeding to apply a clean dressing during R113's observed dressing change for an open stage II coccyx pressure ulcer. During observation at 10:12 a.m. on 1/26/11, clinical manger (CM)-A provided wound care treatment for R113. CM-A washed then gloved her hands, soaked a gauze with normal saline and cleansed R113's coccyx area, wiping around the wound and wound bed, which had a zinc ointment applied. CM-A then took off the glove on her right hand, pulled a glove out her scrub pocket, and placed the glove on her right hand. CM-A was asked if it was her practice to use gloves stored in her scrub pocket at which time, CM-A then ungloved her hands, threw them away, and went into the bathroom to change her gloves. CM-A did not complete hand hygiene after handling soiled gauze and changing her gloves. CM-A confirmed she did not perform hand hygiene after handling the soiled gauze with gloved and after changing her gloves. CM-A stated it was not her practice to complete hand hygiene after handling the soiled gauze and changing gloves when completing a dressing. The Centers for Disease Control (CDC) identifies that hygiene continues to be the primary means of preventing the transmission of infection. The CDC identified hand hygiene was required after handling soiled dressings and after removing gloves.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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: REVISED 2567 AS A RESULT OF AN INFORMAL DISPUTE RESOLUTION On, January 23, 24, 25,and 26, 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were	2 000	REVISED 4/13/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 2 N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess risk and interventions to minimize the risk for pressure ulcer development and worsening of pressure ulcers for 1 of 3 residents (R113) reviewed for pressure ulcers and related to wheelchair positioning needs for 1 of 3 residents (R93) reviewed in the sample for positioning. Findings include: R113 was admitted on 11/25/11 with a stage I pressure ulcer on his coccyx, which developed into two stage II pressure ulcers 12/18/11 and 12/20/11. R113 had diagnoses that included urinary retention, fatigue, severely under weight, advanced dementia with depression and anxiety, and a history of infection. The admission minimum data set (MDS) dated 12/2/11, identified R113 was cognitively intact, no behavioral concerns, and required extensive assistance of one staff for repositioning. The MDS indicated R113 was at high risk for pressure ulcer development and did not have one or more unhealed pressure ulcers at a stage I or higher. The MDS revealed skin and ulcer treatments included a pressure reducing device for his chair and bed, a turning and repositioning program, and ointments/medication application to his body (not his feet). The admission initial nursing data form, dated 11/25/11, identified R113 had a reddened coccyx	2 540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 3 and identified that a tissue tolerance test was to be completed. R113's tissue tolerance observation for the lying position, dated 11/25/11, identified redness on his coccyx after lying for two hours. The observation form then instructed staff to re-observe after one and a half hours. The observation form asked after one hour was the redness noted over the boney prominences which the facility identified as "Yes, the area remained red, initiate wound care protocols stage I and redo the observation at 1 hour." R113's tissue tolerance for sitting observation dated 11/25/12 read "Unable to assess - resident in lying position through-out shift." The facility did not initiate wound care protocols for a stage I pressure ulcer to monitor the area and did not assess R113 for tissue tolerance while sitting to determine appropriate interventions for repositioning needs. A tissue tolerance skin risk factor evaluation form, dated 12/1/11, noted R113 was at mild risk for skin breakdown. It identified he had a bio foam mattress and pressure redistribution cushion in his wheelchair. It noted he "has a reddened coccyx which was present upon admit" and to apply barrier cream to this area twice daily. On 12/18/11, a weekly wound documentation form was initiated for a stage II pressure ulcer on R113's coccyx. The form indicated R113 had a stage II pressure ulcer on his coccyx measuring 1.5 cm by 1.5 cm by 0.2 cm, with no draining or odor. The treatment included an Allevyn foam dressing and Tena with Zinc. On 12/23/11 the wound was noted to be stable, and was reassessed as a stage II pressure ulcer measuring 0.2 cm by 0.1 cm by 0.1 cm, with the same treatment. On 12/30/11 the wound was	2 540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 4 noted to be improving, and was reassessed as a stage II pressure are measuring 0.4 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/8/12 the wound was noted as stable and was reassessed as a stage II pressure are measuring 0.6 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/17/12 the area was assessed by the wound care practitioner. On 12/20/11 a weekly wound documentation form was initiated for a stage II pressure ulcer identified on the diagram as located on the lower area of the buttock and noted as a "lower open area." The form indicated R113 had a stage II pressure ulcer on his lower buttock measuring 1.8 cm by 1.2 cm by 0.1 cm, with no draining or odor. The treatment included an Duoderm dressing. On 12/25/11 the wound was reassessed as a stage II pressure ulcer measuring 0.2 cm by 1.5 cm with no depth with 100% granulation. At this time an Allevyn foam dressing and Tena with Zinc treatment was applied and the area was noted as improved. On 1/24/12 the wound was reassessed as a stage II pressure area measuring 0.3 cm by 0.2 cm with no depth, the area was noted as dry, the treatment was changed to Mepilex Boarder and was identified as improved. On 1/17/12 the area was assessed by the wound care practitioner. No further documentation was provided to indicate that the area was monitored or assessed from 12/25/11 to 1/17/12. The physician orders and progress notes form dated 1/17/12 identified a wound care consult was completed. The note indicted R113 had stage II skin breakdown on his sacrocoxygeal area for approximately two weeks. The note identified R113 was very thin in stature with a weight of 120 pounds on admit, with an	2 540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 5 approximate eight to ten pound weight loss since then. It noted R113 laid down after breakfast and lunch, used a wheelchair for locomotion, had a foam cushion, and did not elevate the head of his bed. It identified R113 was turned every two hours but turns self back to supine and has an alternating air mattress. The note indicated on exam the coccyx ulcer measured 0.5 cm by 0.5 cm and the right sacral ulcer measured 2 cm x 1 cm; both stage II with scant exudates. The practitioner instructed to continue with the alternate air mattress overlay, lay down every two hours twice a day, try to alternate sides, and apply Mepilex Boarder four by four dressing to coccyx ulcer in a diamond shape, change every other day. Wound care was completed on 1/25/12 and was not due until 1/27/12. At 9:45 a.m. on 1/26/12 this surveyor requested to observe R113 wound and dressing change. Wound care for R 113 was observed at 10:12 a.m. on 1/26/11 and the Mepilex Boarder dressing was not applied to wound. Nursing assistant (NA)-A verified the dressing came off that morning during morning cares. NA-A confirmed she reported that information to registered nurse (RN)-A. R113 was observed to be very thin and his coccyx protruded. The wound was approximately 0.3 by 0.2 with superficial depth. The surrounding skin appeared red and dry. CM-A reported the area was not warm to the touch and confirmed the area had some dry, flaking skin. CM-A applied a Zinc ointment and a Mepilex Boarder dressing to the area in the shape of a diamond. During interview at 10:32 a.m. on 1/26/11, RN-B stated she took over for RN-A at 9:30 a.m. and it was not passed on in report that R113's dressing came off during morning cares.	2 540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 6 During interview at 10:34 a.m. on 1/26/12 clinical manager (CM)-B verified the dressing should have been re-applied if it had fallen off. CM-B stated she expected that information to be passed on in report. CM-B verified the tissue tolerance was not completed and and should have been to determine appropriate timely repositioning intervention. CM-B confirmed the the tracking of the wounds were to be done weekly and that this was not completed for each identified pressure area. CM-B verified during the dressing change the surround area where the Zinc ointment and Mepilex Boarder dressing was applied was dry and verified that these treatments were intended to dry out moist wounds. CM-B stated the wound appeared drier than when she last applied the treatment but did not find this concerning enough to consult with the practitioner to readdress if the current treatment was appropriate to promote healing of the wound. During follow-up interview at 10:48 a.m. on 1/26/12 NA-A stated the staff were expected to place a pillow behind R113's back when repositioning him side to side. NA-A stated R113 frequently moved himself back onto his back. During interview at 11:03 a.m. on 1/26/12, NA-D stated it was not her practice to place a pillow behind R113's back when turning him side to side. The Pressure Ulcer Risk Policy dated 9/11 indicated regardless of the residents total risk score each risk factor and potential causes should be reviewed individually. It instructed to implement interventions according to the Braden score and/or residents individual risk factors identified	2 540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 7 Wheelchair assessment R93 had multiple diagnoses including cerebral vascular accident (CVA). R93 was assessed by facility staff to be alert and oriented according to the most recent care conference review, dated 12/8/11. A review of the MDS (Minimum Data Set) and CAA (Care Area Assessment) dated 6/16/11, revealed no assessment for wheelchair positioning. Review of all assessments completed since 6/11 revealed no assessments were completed for wheelchair positioning. Review of the quarterly care conference documentation dated 12/8/11, 9/14/11, and 6/23/11 revealed wheelchair positioning had never been addressed. On 1/23/12 at 7:30 p.m. and 1/25/12 at 8:00 a.m., R93 was observed to be slouched forward in the wheelchair. Observation on 1/25/12 at 2:00 p.m. revealed only minor changes in his positioning in the wheelchair. When asked, R93 was unable to position himself correctly in the w/c. At that time R93 was asked about his comfort level in the wheelchair. He stated "It's not the best in the west." R93 continued to say it would be better if he could "sit up a little bit better." Review of R93's record revealed no progress notes from therapy or nursing identifying the problem of wheelchair positioning. Interview with Clinical Manager-B (CM-B) indicated she was aware of his positioning issues with the wheelchair. "(R93) has always been a sloucher. I assumed he was comfortable. He	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 8 never said anything to me." CM-B admitted she had never asked R93 about his wheelchair, but "I'll talk to him about it." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise policies and procedures pertaining to resident assessment to assure they comply with the regulations, retrain staff and develop a monitoring procedure. TIME PERIOD FOR CORRECTION: Fourteen (14) Days	2 540		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on record observation, interview and document review, the facility failed to develop a comprehensive care plan related to contact precautions for 1 of 1 residents (R67) in the sample reviewed for infection control protocols.	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 9 Findings include: R67 did not have a comprehensive care plan related to infection control precautions. R67 had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11, R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room since this date, according to the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12. During observations of care at 8:00 a.m. on 1/25/12, R67 was observed in a private room. Nursing assistant (NA)-A was observed to gown and glove prior to entering the room and indicated R67 was in isolation due to a c-diff infection. Review of the care plan identified the problem of R67's c-diff infection. The problem was initiated 1/11/12. The goal was for the resident to have no complications related to the infection. The care plan identified multiple interventions including to monitor the resident, education and disinfecting equipment used before it leaves the room. The care plan failed to identify the contact precautions, if the resident could leave the room and if so what needed to be done prior to the resident leaving the room, at what point the isolation precautions could be lifted, and what psychosocial things were going to be done while R67 was required to stay in her room. Clinical Manager (CM)-C stated at 10:20 a.m. on	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 10 1/26/12, the DON wrote R67's care plan. At 10:50 a.m. on 1/26/12 the DON stated "This was new to us [treating C-diff} so we're really working hard to get it right." After review of the assessment of R67's progress at 1:30 p.m. on 1/26/12, she stated "I guess I didn't add it to the actual care plan. I believe it was included [contact precautions] on the aide sheet." When the aide sheet was reviewed together, it failed to identify contact precautions but did identify the c-diff infection. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could provide education for the licensed staff regarding the importance of developing individualized care plans . The Director of Nursing could randomly audit resident charts to ensure the plans of care were completed appropriately. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 555		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by:	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 11 Based on interview and document review, the facility failed to ensure each resident's plan of care was revised as appropriate related to fall risk for 1 of 3 residents (R56) reviewed in the sample for accidents and related to an unavoidable sensory decline in vision for 1 of 1 residents (R56) reviewed in the sample for sensory problems. Findings include: R56 did not have her care plan revised to minimize the risk of further falls following a fall. In addition, the care plan was not revised according to R56's current visual limitations or to assist with maintaining or improving her independence as it related to a decline in vision. R56 had multiple diagnoses including transient ischemic attacks (TIA's), glaucoma and diabetes. An annual minimum data set (MDS) completed on 8/3/11 and the quarterly MDS completed on 10/26/11, indicated R56 was cognitively intact with no signs or symptoms of psychosis. R56 also had no behavioral issues. The MDSs noted R56 had visual impairments but was able to read large print and was able to feed herself meals after the staff "set up" the meal. The MDSs also indicated that R56 had no history of falls. According to progress notes from 8/23/11 through 1/25/12, R56 is alert and oriented with minor forgetfulness. The forgetfulness increased with urinary tract infections (UTI's). R56 had a fall from bed at 1:45 a.m. on 1/20/12. According to the incident report and progress note from the fall, R56 stated she fell while trying to get up to go to the bathroom. R56 was being	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 12 actively treated for a UTI at the time of the fall. Although R56 fell on 1/20/12, there were no interventions put in place to minimize the risk of further falls until 1/24/12. In the area of the incident report directing staff to document immediate interventions implemented, a low bed was identified by the LPN completing the report. However, R56 was already in a low bed at the time of the fall. When asked about the delay in interventions at 3:15 p.m. on 1/24/12, Clinical Manager (CM) B indicated she received the report on 1/23/12. After review, she had further investigation to do before bringing it to the interdisciplinary team (IDTeam) for review. On 1/24/12 CM-B was able to bring the incident report forward to the IDTeam. At that time the team decided to implement a sensor pad alarm which would trigger the call light should R56 attempt to get up from bed independently. CM-B verified the above findings were accurate. When asked what was expected of the floor nurses when the incident occurred, CM-B indicated that the incident should be reviewed by the nurse with appropriate interventions implemented at the time of the incident. CM-B confirmed that the low bed was already in place at the time of the incident. Although a Fall Risk Evaluation had been completed on 1/24/12, it failed to identify R56's significant visual limitations and her acute UTI at the time of the fall. R56 was interviewed at 10:10 a.m. on 1/24/12. She indicated her vision had significantly declined in "the past few months." She further reported that at her last ophthalmology appointment "they	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 13 (the physician) call me legally blind." R56 further stated she "used to" be able to make out the headlines and pictures in the newspaper, but she can no longer do that unless the headlines are "really big." R56 stated "They don't give me a lot of help at meals. I have a hard time feeding myself - getting the food on the fork and getting it to my mouth.' On 1/25/ 12 at 1:30 p.m. Nursing Assistant (NA) C indicated he was aware of R56's visual limitations. He stated "I ask her how she's doing and she always talks about - I'm losing my vision - I can't see that kind of thing." When interviewed at 1:15 p.m. on 1/26/12, Clinical Manager (CM) B indicated she was unaware R56 had significant limitations in her vision. She reported the first time she was aware of the limitation was "yesterday in care conference." She further indicated that after discussion at the care conference, "dietary is going to get her a dark plate so she can see her food better. Part of what we talked about yesterday was to have dietary (staff) explain food and use clock method when the food is provided to her." The current plan of care identified visual limitations on 8/18/11. The goal was to maintain her ability to read large print through the review date of 2/2/12. R56 was no longer able to read most headlines in the newspaper. Further, according to the interview on 1/24/12 at 10:10 a.m. R56 struggled to eat independently, could no longer see to pick out her clothing and could make out large objects within her environment but was unable to determine what those objects were in most cases. R56's care plan failed to be revised with appropriate interventions to assist	2 560		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 14 with the identified decline in vision. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions to meet the needs of residents A monitoring program could be established in order to assure on-going and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not ensure each resident received the necessary care and services related to wheelchair positioning for 1 of 3 residents (R93) reviewed in the sample for positioning. The facility failed to ensure timely interventions to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15 minimize the risk of falls for 1 of 3 residents (R56) reviewed in the sample for accidents. Findings include: R93 did not receive assistance with the identified problem of wheelchair positioning. R93 had multiple diagnoses including cerebral Vascular Accident (CVA). R93 was assessed by facility staff to be alert and oriented according to the most recent care conference review, dated 12/8/11. Although R93 has been seen by Occupational Therapy in the past, R93 had never been seen by therapy for wheelchair positioning. At 7:30 p.m. on 1/23/12 and 8:00 a.m. on 1/25/12, R93 was observed to be slouched forward with pelvis pushed forward in wheelchair and a large gap between his back and the back of the wheelchair. In addition his pelvis was somewhat twisted in the chair with his left hip tight against the side of the wheelchair. Upon request at 7:30 p.m. on 1/23/12, R93 could independently adjust himself in the wheelchair, however he was unable to get his pelvis back and centered in the wheelchair. An interview with R93 was completed at 8:00 a.m. on 1/25/12 and was asked about his comfort level in the wheelchair. He stated "It's not the best in the west." R93 continued to report "it would be better if he could sit up a little bit better". When asked what he would like done differently about his wheelchair, he commented he thought a "little bigger chair" would be helpful. R93 indicated he would be receptive to assistance with wheelchair positioning as it would be "a little easier to sit in all day." Review of R93's record revealed no progress	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16 notes from therapy or nursing identifying the problem of wheelchair positioning. Interview with Clinical Manager (CM)-B indicated she was aware of his positioning issues with the wheelchair. "(R93) has always been a sloucher. I assumed he was comfortable. He never said anything to me." CM-B admitted she had never asked R93 about his wheelchair, but "I'll talk to him about it." Falls R56 had a fall which was not reviewed in order to ensure adequate safety interventions for 4 days. R56 had multiple diagnoses including transient ischemic attacks (TIA's), glaucoma, and was currently being treated for a urinary tract infection (UTI). According to consistent daily progress notes, R56 was assessed by the facility to be alert and oriented with forgetfulness which was worse when R56 had a UTI. The Fall Risk Evaluation completed 8/3/11, identified R56 to be at low risk for falls. The evaluation identified "will self transfer at times, forgetful, doesn't know limitations, extensive assist with transfers, doesn't always remember to use call light, raised edge mattress in place." The care plan initiated 8/18/11, identified limited physical mobility with a goal to "remain free from falls through the review date." The goal had been reviewed with an updated review date of 2/2/12. The care plan contained multiple interventions to maintain mobility and the safety interventions were "Raised edge mattress in place to orient her	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 to bed parameters. Keep bed in lowest position to prevent injury. Reminder sign in place to remind (R56) to use call light and wait for assist. Provide verbal reminders of call light use with each application." R56 had a fall on 1/20/12 at 1:45 a.m. According to the incident report and progress notes for this date and time, R56 was attempting to get up and go to the bathroom. R56 got up from the window side of the bed and was found sitting on buttocks by bed. R56 normally gets up from bed on the side nearest the bathroom. The call light was within reach but was not used. In the section for immediate interventions following the fall, the completing LPN indicated "low bed" which was already in place at the time of the fall. This fall was not reviewed by the interdisciplinary team with interventions implemented until 1/24/12. According to Clinical Manager(CM)-B at 3:15 p.m. on 1/24/12, "Whoever the floor nurse is fills out the incident report and notifies family and physician. Then the incident reports go to the nurse manager and we discuss it in morning meetings, figure out interventions or we further investigate. Thursdays are the safety meeting. Therapy is not always at safety meeting but can call them and have them come down for a specific resident. We review all falls and interventions we put in place. If interventions are effective we close the incident report. If they're not effective or we have more to do, we leave the report open and continue to re-evaluate until we feel we came to a good solution." With regard to falls on Friday night or over the weekend, CM-B indicated "The nurse managers are on call but if there's nothing alarming, we review it Monday morning. We try and check in on the week end. They usually call us but sometimes they don't, so	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 18 we call and check in and we may review it then." When asked why this fall waited for 4 days to be reviewed and have interventions put in place for safety, CM-B indicated that she had some questions regarding the fall and had to investigate on 1/23/12. She further stated that once her investigation was completed, she was able to review it with the interdisciplinary team on 1/24/12. CM-B indicated "We're going to put a bed sensor pad on her bed which will trigger her call light if she gets up. (R56) is a little more forgetful - she got up on window side of the bed instead of the door side. In this case it did wait until Tuesday for intervention because it took me awhile to finish up the investigation." CM-B verified that R56 is " a little more confused" at night. The Fall Risk Evaluation dated 1/24/12, after the fall, identified R56 remained a low risk for falls. It should be noted that R56 was being treated for a UTI at the time of the fall, which was not included in the evaluation. Further, the evaluation failed to include R56's significant visual limitations - indicating only that her vision was "impaired - sees large print, but not regular print in newspapers/books." The bed sensor was observed to be added to R56's bed on 1/24/12 and had been added to the care plan. However, the care sheet utilized by the nursing assistants failed to include the addition of the sensory pad to the bed. During an interview with R56 at 10:25 a.m. on 1/24/12, R56 indicated she "forgot" to use the call light the night of the fall. She further indicated she's been having problems with incontinence, but the problem is improving since working with therapy on it. She further stated "when you gotta go, you gotta go" and she just wanted to get to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 the bathroom. "I hate to wet myself." SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all residents are properly positioned and residents at risk for falls have timely interventions implemented to minimize the risk. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. 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 pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 20 review the facility failed to monitor and provide treatment to minimize the risk and promote healing of pressure ulcers for 1 of 3 residents (R113) reviewed for pressure ulcers. Findings include: R113 was admitted on 11/25/11 with a stage I pressure ulcer on his coccyx which developed into two stage II pressure ulcers on12/18/11 and 12/20/11. R113 had diagnoses that included urinary retention, fatigue, severely under weight, advanced dementia with depression and anxiety, and a history of infection. The admission minimum data set (MDS) dated 12/2/11 identified R113 had no cognitive impairments, no behaviors, and required extensive assistance of one staff for repositioning. The MDS indicated R113 was at high risk for pressure ulcer development and did not have one or more unhealed pressure ulcers at a stage I or higher. The MDS revealed skin and ulcer treatments included a pressure reducing device for his chair and bed, a turning and repositioning program, and application of ointments/medication other than to his feet. The admission initial nursing data form dated 11/25/11 identified R113 had a reddened coccyx and a tissue tolerance was to be completed. R113's tissue tolerance observation for the lying position dated 11/25/11 identified staff observed his current skin integrity after two hours and redness was noted on his coccyx. The observation form then instructed staff to re-observe after one and a half hours. The	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 21 observation form asked after one hour was the redness noted over the boy prominence's which the facility identified as "Yes, the area remained red, initiate wound care protocols stage I and redo the observation at 1 hour." R113's tissue tolerance for sitting observation dated 11/25/12 read "Unable to assess - resident in lying positioning through-out shift." The facility did not initiate wound care protocols for a stage I pressure ulcer to monitor the area and did not assess R113 for tissue tolerance while sitting to determine appropriate interventions for repositioning needs. A tissue tolerance skin risk factor evaluation form dated 12/1/11 noted R113 was at mild risk for skin breakdown. It identified he had a bio foam mattress and pressure redistribution cushion in wheelchair. It noted he "has a reddened coccyx which was present upon admit" and to apply barrier cream to this area twice daily. R113's plan of care, dated 12/13/11, identified he had a stage I pressure ulcer on his coccyx related to immobility and low body weight. The interventions included the application of barrier cream to his coccyx and that he was turned and repositioned throughout the day and repositioned during routine rounds on the night shift. It also identified he was to utilize a biofoam mattress and pressure redistribution cushion in his wheelchair. On 12/18/12 the care plan was updated to include an air mattress overly to the bed. On 12/18/11, a weekly wound documentation form was initiated for a stage II pressure ulcer on R113's coccyx. The form indicated R113 had a stage II pressure ulcer on his coccyx measuring 1.5 cm by 1.5 cm by 0.2 cm, with no draining or	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 22 odor. The treatment included an Allevyn foam dressing and Tena with Zinc. On 12/23/11 the wound was noted to be stable, and was reassessed as a stage II pressure ulcer measuring 0.2 cm by 0.1 cm by 0.1 cm, with the same treatment. On 12/30/11 the wound was noted to be improving, and was reassessed as a stage II pressure are measuring 0.4 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/8/12 the wound was noted as stable and was reassessed as a stage II pressure are measuring 0.6 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/17/12 the area was assessed by the wound care practitioner. On 12/20/11, a weekly wound documentation form was initiated for a stage II pressure ulcer identified on the diagram as located on the lower area of the buttock and noted as a "lower open area." The form indicated R113 had a stage II pressure ulcer on his lower buttock measuring 1.8 cm by 1.2 cm by 0.1 cm, with no draining or odor. The treatment included an Duoderm dressing. On 12/25/11 the wound was reassessed as a stage II pressure ulcer measuring 0.2 cm by 1.5 cm with no depth with 100% granulation. At this time an Allevyn foam dressing and Tena with Zinc treatment was applied and the area was noted as improved. On 1/24/12 the wound was reassessed as a stage II pressure area measuring 0.3 cm by 0.2 cm with no depth, the area was noted as dry, the treatment was changed to Mepilex Boarder and was identified as improved. On 1/17/12 the area was assessed by the wound care practitioner. No further documentation was provided to indicate that the area was monitored or assessed from 12/25/11 to 1/17/12. The physician orders and progress notes form	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 23 dated 1/17/12 identified a wound care consult was completed. The note indicted R113 had stage II skin breakdown on his sacrocoxygeal area for approximately two weeks. The note identified R113 was very thin in stature with a weight of 120 pounds on admit, with an approximate eight to ten pound weight loss since then. It noted R113 laid down after breakfast and lunch, used a wheelchair for locomotion, had a foam cushion, and did not elevate the head of his bed. It identified R113 was turned every two hours but turns self back to supine and has an alternating air mattress. The note indicated on exam the coccyx ulcer measured 0.5 cm by 0.5 cm and the right sacral ulcer measured 2 cm x 1 cm; both stage II with scant exudates. The practitioner instructed staff to continue with the alternate air mattress overlay, lay down every two hours twice a day, try to alternate sides, and apply Mepilex Boarder four by four dressing to coccyx ulcer in a diamond shape, and to change this dressing every other day. Wound care was completed on 1/25/12 and was not due until 1/27/12. At 9:45 a.m. on 1/26/12, this surveyor requested to observe R113 wound and dressing change. Wound care for R113 was observed at 10:12 a.m. on 1/26/11 and the Mepilex Boarder dressing was not applied to wound. Nursing assistant (NA)-A verified the dressing came off that morning during morning cares. NA-A confirmed she reported that information to registered nurse (RN)-A. R113 was observed to be very thin and his coccyx protruded while his buttock tissue appeared to sag and sink in giving the appearance of no buttock. The wound was approximately 0.3 by 0.2 with superficial depth. The surrounding skin appeared red and dry. CM-A reported the area was not warm to the touch and confirmed the area had	2 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 24 some dry, flaking skin. CM-A applied a Zinc ointment and a Mepilex Boarder dressing to the area in the shape of a diamond. During interview at 10:32 a.m. on 1/26/11 RN-B stated she took over for RN-A at 9:30 a.m. and it was not passed on in report that R113's dressing came off during morning cares. During interview at 10:34 a.m. on 1/26/12, clinical manager (CM)-B verified the dressing should have been re-applied if it had fallen off. CM-B stated she expected that information to be passed on in report. CM-B verified the tissue tolerance was not completed and should have been used to determine appropriate timely repositioning intervention. CM-B confirmed the tracking of the wounds were to be done weekly and this, was not completed for each identified pressure area. CM-B verified during the dressing change, the surrounding area where the Zinc ointment and Mepilex Boarder dressing was applied was dry and verified that these treatments were intended to dry out moist wounds. CM-B stated the wound appeared drier then when she last applied the treatment but did not find this concerning enough to consult with the practitioner to readdress if the current treatment was appropriate to promote healing of the wound. During follow-up interview at 10:48 a.m. on 1/26/12, NA-A stated the staff were expected to place a pillow behind R 113's back when repositioning him side to side. NA-A stated R113 frequently moved himself back onto his back. During interview at 11:03 a.m. on 1/26/12 NA-D stated it was not her practice to place a pillow behind R113's back when turning him side to side.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 25 The Pressure Ulcer Risk Policy, dated 9/11, indicated regardless of the residents total risk score each risk factor and potential causes should be reviewed individually. The policy also instructed staff to implement interventions according to the Braden score and/or resident's individual risk factors that were identified. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident was provided with appropriate treatment and services to maintain or improve their abilities related to an unavoidable sensory decline in vision for 1 of 1 residents (R56) reviewed in the sample for sensory problems. Findings include: R56 had a significant decline in vision without intervention. R56 had multiple diagnoses including glaucoma, diabetes, and diabetic retinopathy. The care area assessment (CAA) for vision, dated 8/17/11, indicated R56 had impaired vision due to difficulty reading regular print but was able to read large print and see objects in the environment. The assessment failed to include the diagnoses of glaucoma, history of cataracts or transient ischemic attack (TIA), both of which could contribute to a visual decline. The most current nutrition assessment completed 11/2/11, identified R56 as sighted with no problems feeding self. The current care plan, revised 11/11, identified impaired vision. The established goal was to maintain the ability to read large print. The approaches included "Monitor/document/report to MD the following signs/symptoms of acute eye problems: Change inability to perform ADL's	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 27 (Activities of Daily Living), decline in mobility, sudden visual loss, pupils dilated, gray, or milky, complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision." The care plan did not identify any assistive devices for improving her vision or assisting R56 to maintain her independence. R56 had ophthalmology visits on 5/17/11 and 11/17/11. She was identified with open angle glaucoma in both eyes and pseudophakia in both eyes. The physician noted the onset to be gradual and no change in treatment was recommended. R56 was interviewed at 10:10 a.m. on 1/24/11, her vision had significantly declined in "the past few months." She further indicated that at her last ophthalmology appointment "they [physician]call me legally blind." She reported to" be able to make out the headlines and pictures in the newspaper, but she can no longer do that unless the headlines are "really big." R56 stated "They [facility staff] don't give me a lot of help at meals. I have a hard time feeding myself - getting the food on the fork and getting it to my mouth.' When asked if she's talked with therapy about her problems maintaining independence at meals or if any adaptive equipment had been offered, R56 stated "No, they've never given me anything like that." During an interview at 1:50 p.m. on 1/25/12 , R56 verbalized that wanted to make certain staff understood she wanted to remain as independent as possible and stated "I like to be independent. I just really want to do things for myself as much as I can. I don't want everyone to know I can't see. The aides know - they pick out my clothes for me in the morning."	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 28 On 1/25/ 12 at 1:30 p.m., nursing assistant (NA) -C indicated he was aware of her visual limitations. He stated "I ask her how she's doing and she always talks about losing her vision" and that she "can't see" When interviewed at 1:15 p.m. on 1/26/12, Clinical Manager (CM)-B indicated she was unaware R56 had significant limitations in her vision. She indicated the first time she was aware of it was "yesterday in care conference." She further indicated that after discussion "Dietary is going to get her a dark plate so she can see her food better. I should make her an eye appointment to get her vision checked. I wasn't aware her sight was that bad. Her last ophthalmology appointment was 11/17/11 - there was nothing specific about visual ability. Part of what we talked about yesterday was to have dietary explain food and use clock method when the food is provided to her." SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the care and services for residents with a visual decline. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 915		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary	21015		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 29 procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to store food service equipment in a sanitary manner to prevent the transmission of food bourne illness and physical contamination to food, having the potential to affect 70 of 70 residents who ate at the facility. Findings include: During the initial kitchen observation at 1:33 p.m. on 1/23/12, the Hobart meat slicer was stored on the counter top covered and was considered clean. The meat slicer had an accumulate of food residue on the blade rotator and sharpener component, which was an area in which food came in contact with when slicing. The stove hood vents, situated above the grill and open cooking range, were soiled with a brown/black substance and thick layer of dust build up. An Edmund industrialized sized can opener was attached to the end of the steam table area. The can opener blade was dull and had metal chard's behind the blade. Dietary manger (DM) confirmed these observations. During interview at 1:42 p.m. on 1/23/12, Cook-A confirmed the meat slicer was last used yesterday for slicing roast beef. Cook-A demonstrated how to take apart the meat slicer for cleaning. Cook-A stated she was unaware the	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 30 sharpener component, the area in which had an accumulate of food residue, was removable for cleaning and sanitizing. During interview at 1:44 p.m. on 1/23/12, DM stated staff were to take apart the meat slicer after every use, clean and sanitize the machine and send the detachable components through the dishwasher, including the sharpener component. DM reported she was unsure the last time the blade was changed on the industrial sized can opener because it was rarely used but confirmed staff used it on occasion. During a follow-up observation at 7:32 a.m. on 1/25/12, Cook-B was asked to disassemble the meat slicer, which was covered and considered clean. Cook-B detached the sharpener competent. The blade rotator situated under the sharpener component had a build up of food residue. Cook-B confirmed the observation and without cleaning or sanitizing the machine, reassembled the machine and covered it for the next use. Cook-B reported the meat slicer was used one to two times a week to slice meats. During a follow-up observation at 1:35 p.m. on 1/26/12, DM was asked to disassemble the meat slicer, which was covered and considered clean. DM detached the sharpener competent. The blade rotator situated under the sharpener component had a build up of food residue. DM stated she asked staff to clean and sanitize the machine after the first observation on 1/23/12 but did not follow-up to monitor if the task was done appropriately. DM verified the stove hood vents had not been cleaned and still contained brown/black substance and thick layer of dust build up. DM stated she did not have the vents cleaned because "they were just cleaned on the	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 31 fourth." DM further stated if she observed something that was soiled or dirty it would be cleaned. DM stated the stove hood vents should have been cleaned after the initial observation and may need to be cleaned more frequently to prevent dust build up. The Hobart meat slicer instructions for cleaning dated 2/01, identified the meat slicer had a top knife cover (sharpener component) that contained the meat slicer sharpener. The instructions indicated the meat slicer machine must be thoroughly cleaned and sanitized after each day's operation or after being idle for an extended period of time. It instructed to remove the sharpener and top knife cover. It identified the top knife cover, deflector and the sharpener housing unit (also part of the sharpener component) needed to be wiped out with no residue remaining inside the sharpener housing unit and on the blade and clean the sharpener in a sink. It instructed to rinse with fresh water and to not wash the slicer components in the dishwasher R42 obtained ice for ice water from the large Ice machine in the North Dining Room without practicing good infection control technique, potentially contaminating the ice machine. At 1:00 p.m. on 1/25/12, R42 entered the dining room to get ice for water. She took the scoop out of the bin and set it on the counter. R42 walked to the sink and dumped part of water from the pitcher. R42 went back to the ice machine with the pitcher. Holding the water pitcher inside of ice machine, R42 used the public scoop to place ice inside of her pitcher coming in contact with pitcher. R42 packed the ice down with the scoop and added more ice again coming in contact with	21015		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 32 the pitcher. R42 placed the scoop in the ice machine while she set the pitcher down on her walker. R42 then returned the scoop to the plastic bin for ongoing use. At that time R42 verified the pitcher was hers that she had been using the pitcher "since yesterday. I get my own ice water every day. The staff is just so busy." Although there were 4 staff members in the dining room at the time of this incident, no staff intervened with the practice. Nursing Assistant (NA)-C at 1:30 p.m. on 1/25/12 stated "I saw her come in and get her ice. She's really clean. As long as they (residents) wash their hands and stuff, it hasn't been a problem. She's a really clean person. She always gets her own (ice). I've never noticed it to be a problem." When the observation was described to the Infection Control Nurse and the Director of Nursing (DON) at 12:45 p.m. on 1/26/12, the DON stated she would work on this issue as it was "not my first choice" for practice. SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding proper cleaning of kitchen equipment. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment. TIME PERIOD FOR CORRECTION: 15 (fifteen days)	21015		
21045	Mn Rule 4658.0620 Subp. 4 Frequency of Meals; Dining Room	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 33 Subp. 4. Dining room. Meals are to be served in a specified dining area consistent with the resident's choice and plan of care. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that residents had choices related to food and snacks for 5 of 5 residents (R25, R67, R56, R46, R28) in the sample reviewed for choices. Findings include: R46 reported during an interview at 10:55 a.m. on 1/24/12, that dietary staff " just serves the meal " and does not feel that she was given a choice of foods at meal times. R46 reported " would like to have a choice of food that she eats. " R46 had multiple diagnoses, including above the knee amputation, esophageal reflux, persistent mental disorder, and depressive disorder. An annual minimum data set (MDS) was completed on 8/3/11 and a quarterly MDS was done on 10/27/11. Both MDSs indicated R46 was cognitively intact with no signs or symptoms of delirium, psychosis or any behavioral issues. She had no communication barriers and was generally independent with eating after staff set up her meals. R46 was again interviewed at 8:09 a.m. on 1/25/12. She was eating her breakfast and reported that she was not satisfied with breakfast served as food was cool. She Indicated that she would talk to dietary staff about this but no dietary staff were available.	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 34 R46 was interviewed again at 1:05 p.m. on 1/25/12. Resident was sitting at a table in the dining room with her noon meal in front of her. She was not eating and appeared upset. She reported that she did not like what was served. She indicated the carrots were cold and she did not like the pork patty. Again, she reported she would have told the dietary staff about this and requested an alternative, but no dietary staff was available. An interview was completed with Dietary Aide (DA)-A, who reported an alternate was available to all residents if they do not like what was served for the main entrée. DA-A indicated the alternate was not posted and so residents do not know what the alternate would be. If a resident voices that they do not like the main entrée, dietary staff will request an alternate from the cook. DA-A reported that soup and sandwiches are always available to residents at their request. An interview was completed with the Dietary Manager at 12:34 p.m. on 1/25/12. She reported that she was unaware of R56 ' s complaint of not having choices for meals. The DM did report R56 did have problems asserting herself at times and if she was dissatisfied with food served, may not say anything to staff. The DM reported that at the present time, the facility had a fairly passive population, who may not report any concerns they have. The DM did indicate that after the meal was served, dietary staff do not check with residents regarding their meal satisfaction and so she did verify that there would not be any dietary to tell if they did not like what was served. An interview with registered nurse Clinical Manager (CM) C was completed at 1:15 p.m. on	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 35 1/25/12. CM-C reported that R56 had not voiced any complaints regarding not having choices for food or any dissatisfaction regarding food choices. CM-C did indicate that if R56 had any concerns, she would generally talk to her daughters, who would bring the issue to the nursing staff. CM-C reported " R56 does have a hard time voicing concerns. " R28 was not provided the dietary plan requested by family members. A telephone interview was completed at 11:25 a.m. on 1/24/12 with R28 ' s family-A, who reported that the family was very concerned regarding R28 ' s weight gain since admission to the facility. Family-A stated that R28 had gained 8 pounds in the recent past and she had talked to the facility ' s Dietary Manager about this. Family -A indicated they had requested R28 not receive any " sugary snacks " but the ' facility does not seem to get it ' and continues to provide sugary snacks during snack pass. " Family-A stated she and her sister had requested R28 be given a piece of fruit at snack time. Family-A reported that her mother will eat whatever anyone gives her too eat and even if R28 was full, will eat it until it is gone. R28 had a current diagnosis that included dementia, carcinoma of unspecified part of intestine, abnormality of gait, atrial fibrillation and hypothyroidism. According to the significant change MDS, completed on 12/29/11, R28 had both long and short term memory issues and was severely cognitively impaired. She had problems understanding and making self understood at times. She needed extensive assistance of 2	21045		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 36 facility staff for ADLs (activity of daily living) and needed limited assistance of one staff at mealtime. An interview was completed with the Dietary Manager (DM) at 12:34 p.m. on 1/25/12, who reported she was aware that family was very concerned regarding resident ' s weight gain. DM reported that she had negotiated with the family to put resident on " small portions " and since doing this, R28 had " lost a few pounds " . DM indicated she did not feel that it was " right to withhold sugary snacks " from R28 and reported she was under the impression the family was accepting of the small portions to R28 ' s diet and were willing to bypass the ' fruit only for snack ' request. The DM did report that R28 was unable to make personal choices regarding meal choices and ate whatever staff gave her. R25 did not receive an opportunity for choice at snack times. During interview at 6:30 p.m. on 1/23/12, R25 stated "I get hungry in between meals. I'd like something that will tide me over - like a half sandwich or something-nothing sweet." At 2:15 p.m. on 1/25/12, R25 indicated she had told nursing staff she gets hungry between meals and she did not like sweets but she hasn't seen anything done about the report yet. R25 had multiple diagnoses including pyelonephritis and malaise/fatigue. The Minimum Data Set (MDS) dated 12/23/11 identified R25 as alert and oriented. An observation of the snack cart at 8:00 p.m. on 1/23/12 revealed cookies as the primary snack	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 37 with substantial snacks of sandwiches provided to specific residents. The cart also contained juice. When asked at 2:00 p.m. on 1/26/12, Clinical Manager(CM) B indicated R25's request came up in care conference in 12/11. CM-B stated "We told her there's always sandwiches or snacks available, she just has to ask. There's always sandwiches on the cart and I wonder why she (R25) doesn't know that. Sometimes the kitchen has made special snacks for people - they would make one especially for the resident. I don't think we talked about just sending her up something - it just came up briefly." An interview at 9:30 a.m. on 1/26/12 with the Dietary Manager (DM) was completed. The DM reported she was unaware of the R25's request. The DM also stated "They (the residents) just need to ask." R67 did not receive an opportunity for choice at meal times. R67 had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11 R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room, according to the Director of Nursing (DON) during an interview at 1:30 p.m. on 1/26/12. At 9:00 a.m. on 1/25/12, R67 received her breakfast tray from staff of scrambled eggs, cereal and yogurt. Staff left room after setting up R67's tray. There was no offer of choice prior to	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 38 the staff member leaving the room. R67 indicated she was "so tired of eggs". R67 clarified she "will eat a soft egg - like a fried egg - but sick of scrambled eggs. I got them every morning for 5 months at my previous place. That was a nice place - you could choose what you wanted to eat." When asked if she got choices with her meals now, R67 stated "No, not at all. You get what you get." According to Clinical Manager (CM) C at 10:30 a.m. on 1/26/12 , "(R67) is informed at care conferences and resident council to ask for something different if she doesn't like it. There's always second choices-she has asked for something different when she doesn't like it." R67 stated at 10:50 a.m. on 1/26/12 "I've been in this room a long time. There's not always someone to tell if I don't like it." R67 further stated she was "not fussy but it would be kind of nice to have some options." R56 was not offered an opportunity for choice at meal times. Upon interview at 10:10 a.m. on 1/24/12, R56 indicated there was no choice for meal selection at meal time. She stated "When I don't like it, you're stuck with it." R56 had multiple diagnoses including Diabetes and Glaucoma. R56 was assessed by staff as alert and oriented with minor forgetfulness according to progress notes. Observation of the lunch meal in the north dining room on 1/25/12 revealed R56 did not eat her meat. There was no staff available in the dining room for residents to ask for an alternate selection. An interview with R56 at 1:50 p.m. on	21045		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 39 1/25/12 indicated "I don't care for pork. I thought it was fish. I only had a bite. I didn't care for it. They didn't offer me anything else. I just ate the potatoes. They never ask (if I would like something different)." Interview with the Dietary Manager (DM) at 9:30 a.m. on 1/26/12 indicated "(R56) had never told me she didn't like pork." The DM indicated residents need to indicate they do not like something in order to get something different. When asked how resident's were supposed to report it when there was no staff available in the dining room to tell, the DM stated "Good point - there are no staff to tell if they don't like the food served." The DM also indicated that residents can review the posted menu on their way through the door and if they don't like something just let someone know and they will provide a substitute prior to the resident's food being served. When asked how resident's can review the menu if they are unable to visualize the menu or can't read the DM again stated "residents can tell staff they don't like the food being served and they would be offered something else." "We always have leftovers available in the freezer or soup and sandwich available." When interviewed at 2:20 p.m. on 1/26/12, Clinical Manager(CM) B indicated she was unaware R56 was having an issue with choices at meal time. "She's pretty good about making her needs known." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and the Director of Dietary Services could schedule an in service for all nursing and dietary staff to stress the importance of offering each resident choices of	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 40 food at meal times and snacks. The quality assurance committee could establish a system to audit staff to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21045		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement and maintain an infection control program to help prevent the development and transmission of infections, failure to follow the recommendations for hand hygiene, appropriate implementation of contact precautions, and proper sanitation of cleaning equipment. This deficient practice had the potential to effect all 70 residents who resided in the facility. Findings include: Although R67 was in contact precautions, staff did not consistently utilize the contact precautions appropriately as directed by facility policy. R67 did not have a comprehensive care plan related to infection control precautions. R67 was admitted to the facility on 11/2/11. She had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On	21375		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 41 12/30/11, R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room according to the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12. At 9:05 a.m. on 1/25/12, R67 was served her breakfast tray. Nursing Assistant (NA)-A entered the room without donning personal protective equipment (PPE). NA-A set up R67's tray, placed it on the over-bed table, touching the table with her hands and brushing against it with her uniform. NA-A then assisted R67 to wash her hands, placed sanitizing gel in her own hands and applied the gel onto R67's hands, assisted resident to wash her hands prior to eating. NA-A placed the spoon in R67's hand. NA-A then left R67's room, utilizing sanitizing gel to her own hands. NA-A left the room to get a clothing protector and straws. NA-A again entered the room with no PPE, placed straws in R67's drinks and placed the clothing protector around R67 coming in contact with R67 and the wheelchair with her hands and uniform. NA-A left the room again, this time without washing her hands. She went to the food tray cart, which was stationed in the hallway by R67's room, to obtain jelly from a public bowl of jelly on top of the cart. NA-A returned to the room with the jelly without washing hands or donning PPE. She then finished setting up the breakfast tray for R67. NA-A did not wash hands upon leaving the room. An interview with NA-A at 9:20 am on 1/25/12, indicated she was told "only have to gown/glove when coming body to body contact." She clarified	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 42 that touching items in the environment wouldn't have been a concern. It's "only if you touch the resident." When asked specifically about touching the resident's hands to wash them and her body to place the clothing protector NA-A stated "Oh yeah you're right I should have put on gloves." NA-A was asked about when to wear a gown and she reported she didn't need to wear one. "Only when doing cares and body to body contact." At 9:35 a.m. on 1/25/12, clinical manager (CM)-A stated "Staff should gown and glove when in direct contact with the resident - although the hands I'm thinking maybe it's not an issue." Explained to CM-A that NA-A washed the residents hands and brushed up against w/c and tray table. CM-A stated "I will check with (the Infection Control Nurse) to be sure what our policy is. She should be washing her hands when she comes into the room and when she leaves the room - foam in foam out." When asked what should be done with the food cart, specifically the bowl of jelly that was potentially contaminated by the infection control breach, CM-A stated "I'm not sure what we would do with the jelly. I will check with (the infection control nurse) and let you know." At 9:50 CM-A returned and verified NA-A should have gowned and gloved if she's brushing up against the resident and wheelchair and touching the resident. When asked what was going to be done with the food cart and the jelly CM-A stated "We should throw away the jelly and wash the bowl obviously." When informed the cart and the jelly remained in the hall for use, CM-A stated "Oh, I'll go get rid of it right now and we'll talk to (NA-A). Interview with the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12 verified this incident was a breach in their	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 43 infection control practice. They further indicated NA-A had been re-educated and they would re-educate other staff as well on the infection control protocols including contact precautions. The facility policy "Contact Precautions" dated 1/08 and provided by the DON as current indicated "Gloves should be worn when entering the room and while providing care for a resident." The policy further directed staff to wash their hands after glove removal and "hands should not touch potentially contaminated environmental surfaces or items." The policy indicated gowns should be worn "if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the room." The policy did not identify the term "substantial". According to the DON at 12:45 p.m. on 1/26/12, she would consider substantial to be if the staff member was going to physically come in contact with the resident or the environment. Although the policy identified "Patient Transport" there was no definition of when a resident may come out of their room or what precautions needed to be taken to do so Hand hygiene was not completed after handling a soiled dressing, removing gloves and proceeding to apply a clean dressing during R113's observed dressing change for an open stage II coccyx pressure ulcer. During observation at 10:12 a.m. on 1/26/11, clinical manger (CM)-A provided wound care treatment for R113. CM-A washed then gloved her hands, soaked a gauze with normal saline and cleansed R113's coccyx area, wiping around the wound and wound bed, which had a zinc ointment applied. CM-A then took off the glove on her right hand, pulled a glove out her scrub.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 44 pocket, and placed the glove on her right hand. CM-A was asked if it was her practice to use gloves stored in her scrub pocket at which time, CM-A then ungloved her hands, threw them away, and went into the bathroom to change her gloves. CM-A did not complete hand hygiene after handling soiled gauze and changing her gloves. CM-A confirmed she did not perform hand hygiene after handling the soiled gauze with gloved and after changing her gloves. CM-A stated it was not her practice to complete hand hygiene after handling the soiled gauze and changing gloves when completing a dressing. The Centers for Disease Control (CDC) identifies that hygiene continues to be the primary means of preventing the transmission of infection. The CDC identified hand hygiene was required after handling soiled dressings and after removing gloves. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21375		
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis	21400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21400	Continued From page 45 Program is walved. Conditions of Waver: - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease. This MN Requirement is not met as evidenced by: Based on interview and document review the facility did not maintain a record of each resident's admission Tuberculosis skin test results, including measured induration for 5 of 6 residents (R67, R85, R115, R78, and R3) reviewed in the sample for immunizations.	21400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21400	Continued From page 46 Findings include: Although R67, R85, R115, R78, and R56 had their mantoux tuberculosis tests administered and read, the facility failed to document the induration results on all 5 residents. Current Centers for Disease Control (CDC) guidelines indicated that millimeters of induration should be documented for all mantoux results. If there is no induration, it is recommended that "0 mm" is documented. R67 was admitted on 11/18/11. She had her first step mantoux administered on 12/3/11 and read on 12/5/11. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 12/10/11 and read on 12/12/11. The results indicated negative but failed to provide any measurement of induration. R85 was admitted on 11/29/11. She had her first step mantoux administered on 11/30/11 and read on 12/2/11. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 12/7/11 and read on 12/9/11. The results indicated negative but failed to provide any measurement of induration. R115 was admitted on 1/6/12. He had his first step mantoux administered on 1/7/12 and read on 1/9/12. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 1/15/12 and read on 1/17/12. The results indicated negative but failed to provide any measurement of induration. R78 was admitted on 1/5/12. She had her first	21400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21400	Continued From page 47 step mantoux administered on 1/6/12 and read on 1/8/12. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 1/13/12 and read on 1/15/12. The results indicated negative but failed to provide any measurement of induration. R3 was admitted on 4/11/11. She had her first step mantoux administered on 4/12/11 and read on 4/14/11. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 4/19/11 and read on 4/21/11. The results indicated negative but failed to provide any measurement of induration. Interview at 1:15 p.m. on 1/25/12 with Clinical Manage-C (CM-C), RN-D and RN-E indicated they don't measure the millimeters of induration when the mantoux result is negative. Interview with the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12 verified it was not something they have asked the staff to do. They further indicated "if we had known we had to it would have been easy to do." Review of the facility policies for staff and resident tuberculosis prevention and mantoux administration dated 8/09 and provided by the facility as current, the policies failed to direct staff to include the millimeters of induration when documenting mantoux results. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure Tuberculosis skin test are done appropriately. Facility staff could be reeducated and an auditing system developed to ensure compliance.	21400		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21400	Continued From page 48 Time Period for Correction: Twenty one (21) days.	21400		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is	21530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 49 the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that each resident's medication regimen was free of irregularities related to the administration of Lanoxin (digoxin, a cardiac medication) without regular monitoring of the pulse for 1 of 10 residents (R91) reviewed in the sample for unnecessary medications. Findings include: R91 did not have the irregularity of digoxin administration without the monitoring of pulse identified by the monthly pharmacist's drug review. R91 had multiple diagnoses including atrial fibrillation. R91 had a Physician's order for Lanoxin (digoxin) 0.25 mg by mouth every day. The order dated back to admission on 6/6/11. R91 was admitted with facility standing orders which included an order to hold the administration of digoxin if pulse less than 55. Review of the medication administration records (MAR's) revealed there was no pulse documented for the months of 11/11, 12/11, or 1/12. There was also no information on the MAR directing the facility staff to hold the digoxin for a pulse less than 55 or a prompt to take the pulse prior to administration. Interview with RN-C on 1/26/12 at 8:15 a.m. revealed "I don't know why we don't take her pulse anymore. I'm thinking we used to but we don't do it anymore - but I don't know why. It's	21530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 50 fallen off for a few residents where we used to do it and now we don't anymore." Clinical Manager-B (CM-B) on 1/26/12 at 8:30 a.m. indicated she had no additional information and verified the orders were accurate and the pulse should have been taken prior to administration of the digoxin. Review of the monthly pharmacy reviews for medication irregularities revealed no issues identified with the administration of the digoxin for the months of 11/11, 12/11, or 1/12. When the November review was completed, the resident was in the hospital. Per the consulting pharmacist on 1/26/12 at 3:15 p.m. he verified the pulse should have been checked prior to administering the digoxin. A SUGGESTED METHOD FOR CORRECTION: The administrator, along with the director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medications. Staff could be trained as necessary. The director of nursing could monitor medication monitoring on a regular basis. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 51 which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received appropriate monitoring of medication for 1 of 10 resident (R91) in the sample reviewed for unnecessary medications. Findings include: An observation of medication administration at 12:25 p.m. on 1/25/12 revealed 91's pulse was not taken prior to the administration of Lanoxin (Digoxin-a cardiac medication) as ordered by her physician. R91 had multiple diagnoses including atrial fibrillation. She had a physician's order for Lanoxin (digoxin) 0.25 mg by mouth every day and according to the facility's standing orders, which were also signed by her physician, staff were directed to not give this medication if R91's pulse was less than 55 beats per minute. A	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 52 review of the medication administration records (MAR's) revealed there was no pulse documented for the months of November, 2011, December, 2011 and January, 2012 There was also no information on the MAR directing the facility staff to hold the digoxin for a pulse less than 55 or a prompt to take the pulse prior to administration. Interview with registered nurse (RN)-C at 8:15 a.m. on 1/26/12 revealed "I don't know why we don't take her pulse anymore. I'm thinking we used to but we don't do it anymore - but I don't know why. It's fallen off for a few residents where we used to do it and now we don't anymore." Clinical Manager (CM)-B at 8:30 a.m. on 1/26/12 verified the physician orders were accurate and the pulse should have been taken prior to administration of the digoxin. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the need for medication monitoring with the licensed staff including the State and federal regulations. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 53 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services in a dignified manner related to visual limitations and the need for meal time assistance for 1 of 3 residents (R56) reviewed in the sample for dignity. Findings include: R56 did not receive meal time assistance in order to ensure a dignified experience when dining. R56 indicated during interview at 10:10 a.m. on 1/24/12, "they (the physician) called me legally blind." She further indicated that she has "gone blind since being here" and her vision had significantly deteriorated in the "last few months". She stated that one of her concerns was "They don't give me a lot of help at meals. I have a hard time feeding myself, getting the food on the fork and getting it to my mouth." R56 had multiple diagnoses including glaucoma and diabetes. During observation at 12:05 p.m. on 1/25/12, R56 wheeled into the dining room and with staff assistance was positioned at her table. R56 was provided hot water by staff and she independently placed her tea bag in the water. There was a bowl already on the table near her other glasses of milk and water. R56 pulled the bowl toward her and stated loudly enough to be easily heard "I don't know what we're eating." R56 then began to eat her lettuce salad, taking the first few bites easily. As there was less salad in the bowl, R56	21805		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 54 used her opposite hand to feel inside the bowl for the lettuce and assist getting the lettuce onto the fork. As she pushed the lettuce onto the fork, she stated "I can't see it." R56 was able to feed herself the salad using both hands and feeling the food with her non-dominant hand. There was a scant amount of lettuce salad left in the bowl. At 12:30 p.m. R56 was provided a plate of food by dietary staff, without any verbal exchange or explanation of her food. R56 then asked her two table mates "What do we have to eat today? What's on my plate? Where is it?" R56 had pork steak, beets, mashed potatoes with gravy, carrots and a slice of bread with butter. R56 was told by table mates what was on her plate; however they were uncertain what the meat was. R56 began to eat her food without staff assistance, feeling her way across her plate with her left hand and a fork in her right hand. Once she was able to feel the food on her plate, she began to eat with a fork. The meat remained a large chunk of meat and had not been cut up in any way. R56 stabbed her fork into the meat in order to break off an approximately 3 cm x 3 cm piece of meat which she placed in her mouth. After that piece of meat she made no further attempts to eat the meat. R56 continued to eat with both hands - her left hand assisted to push food onto the fork, which was held by her right hand. As she attempted to get her food onto the fork, her carrots and beets were pushed off of the plate onto the table. She would pick them up, place them back onto her plate and continue to eat, attempting to push them onto her fork with her free hand. At 12:50 p.m. R56 received her desert of peach cobbler. R56 again asked her table mates what she had to eat. Her table mates were uncertain what it was and as R56 poked her finger into the bowl of cobbler stated "I think it's something apple." R56	21805		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 55 took one bite of cobbler getting only a small portion of the cobbler and whip cream with no peach as the peach kept slipping from the fork. R56 ate the one bite of cobbler and made no further attempts to eat. She had eaten approximately 50% of her meal and drank only her tea. The milk and water at the top of her plate remained untouched. There was a nursing assistant in the dining room throughout the entire meal; however he was feeding other residents at another table several tables away from R56. Multiple dietary staff were in and out of the dining room delivering food. Nursing staff members were in and out of the dining room, bringing residents, delivering medications and removing residents when they were done eating. Although there were multiple staff in the dining room, R56 received no clarifications on what she was eating or offers of assistance. When interviewed at 1:50 p.m. on 1/25/12 after the observed meal, R56 stated "I get by - the girls at my table are really good about telling me what we're eating. I like to be independent. They rush away so quickly, they don't seem to have time to answer my questions. I just really want to do things for myself as much as I can. I don't want everyone to know I can't see." Nursing assistant (NA) C was present in the dining room throughout the entire meal. He was asked specifically about R56's need for meal time assistance and her visual limitations. At 1:30 p.m. on 1/25/12, NA-C stated "She always eats 75% or so of her meals. I ask her how she's doing and she always talks about - I'm losing my vision - I can't see that kind of thing. But she always eats - unless she's sick or something."	21805		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 56 Clinical Manager (CM) B was interviewed at 2:15 p.m. on 1/26/12 about R56's needs for meal time assistance and her visual limitations. She responded that dietary was looking into getting a dark plate in order to see her food better. She further indicated " I should make her an eye appointment to get her vision checked. I wasn't aware her sight was that bad. Her last ophthalmology appointment was 11/17/11 - but there was nothing specific about (R56's) visual ability. Part of what we talked about yesterday (in her scheduled care conference) was to have dietary explain food and use clock method when the food is provided to her." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are treated with dignity. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21805		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	Please see attached Plan of Correction.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services in a dignified manner related to visual limitations and the need for meal time assistance for 1 of 3 residents (R56) reviewed in the sample for dignity. Findings include: R56 did not receive meal time assistance in order to ensure a dignified experience when dining.	F 241 OK JL 3/01/12 mm		

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

Administrator 2/22/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 R56 indicated during interview at 10:10 a.m. on 1/24/12, "they (the physician) called me legally blind." She further indicated that she has "gone blind since being here" and her vision had significantly deteriorated in the "last few months". She stated that one of her concerns was "They don't give me a lot of help at meals. I have a hard time feeding myself, getting the food on the fork and getting it to my mouth." R56 had multiple diagnoses including glaucoma and diabetes. During observation at 12:05 p.m. on 1/25/12, R56 wheeled into the dining room and with staff assistance was positioned at her table. R56 was provided hot water by staff and she independently placed her tea bag in the water. There was a bowl already on the table near her other glasses of milk and water. R56 pulled the bowl toward her and stated loudly enough to be easily heard "I don't know what we're eating." R56 then began to eat her lettuce salad, taking the first few bites easily. As there was less salad in the bowl, R56 used her opposite hand to feel inside the bowl for the lettuce and assist getting the lettuce onto the fork. As she pushed the lettuce onto the fork, she stated "I can't see it." R56 was able to feed herself the salad using both hands and feeling the food with her non-dominant hand. There was a scant amount of lettuce salad left in the bowl. At 12:30 p.m. R56 was provided a plate of food by dietary staff, without any verbal exchange or explanation of her food. R56 then asked her two table mates "What do we have to eat today? What's on my plate? Where is it?" R56 had pork steak, beets, mashed potatoes with gravy, carrots	F 241		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 and a slice of bread with butter. R56 was told by table mates what was on her plate; however they were uncertain what the meat was. R56 began to eat her food without staff assistance, feeling her way across her plate with her left hand and a fork in her right hand. Once she was able to feel the food on her plate, she began to eat with a fork. The meat remained a large chunk of meat and had not been cut up in any way. R56 stabbed her fork into the meat in order to break off an approximately 3 cm x 3 cm piece of meat which she placed in her mouth. After that piece of meat she made no further attempts to eat the meat. R56 continued to eat with both hands - her left hand assisted to push food onto the fork, which was held by her right hand. As she attempted to get her food onto the fork, her carrots and beets were pushed off of the plate onto the table. She would pick them up, place them back onto her plate and continue to eat, attempting to push them onto her fork with her free hand. At 12:50 p.m. R56 received her desert of peach cobbler. R56 again asked her table mates what she had to eat. Her table mates were uncertain what it was and as R56 poked her finger into the bowl of cobbler stated "I think it's something apple." R56 took one bite of cobbler getting only a small portion of the cobbler and whip cream with no peach as the peach kept slipping from the fork. R56 ate the one bite of cobbler and made no further attempts to eat. She had eaten approximately 50% of her meal and drank only her tea. The milk and water at the top of her plate remained untouched. There was a nursing assistant in the dining room throughout the entire meal; however he was feeding other residents at another table several	F 241		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3	F 241		

tables away from R56. Multiple dietary staff were in and out of the dining room delivering food. Nursing staff members were in and out of the dining room, bringing residents, delivering medications and removing residents when they were done eating. Although there were multiple staff in the dining room, R56 received no clarifications on what she was eating or offers of assistance.

When interviewed at 1:50 p.m. on 1/25/12 after the observed meal, R56 stated "I get by - the girls at my table are really good about telling me what we're eating. I like to be independent. They rush away so quickly, they don't seem to have time to answer my questions. I just really want to do things for myself as much as I can. I don't want everyone to know I can't see."

Nursing assistant (NA) C was present in the dining room throughout the entire meal. He was asked specifically about R56's need for meal time assistance and her visual limitations. At 1:30 p.m. on 1/25/12, NA-C stated "She always eats 75% or so of her meals. I ask her how she's doing and she always talks about - I'm losing my vision - I can't see that kind of thing. But she always eats - unless she's sick or something."

Clinical Manager (CM) B was interviewed at 2:15 p.m. on 1/26/12 about R56's needs for meal time assistance and her visual limitations. She responded that dietary was looking into getting a dark plate in order to see her food better. She further indicated " I should make her an eye appointment to get her vision checked. I wasn't aware her sight was that bad. Her last ophthalmology appointment was 11/17/11 - but

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4 there was nothing specific about (R56's) visual ability. Part of what we talked about yesterday (in her scheduled care conference) was to have dietary explain food and use clock method when the food is provided to her."	F 241		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that residents had choices related to food and snacks for 5 of 5 residents (R25, R67, R56, R46, R28) in the sample reviewed for choices. Findings include: R46 reported during an interview at 10:55 a.m. on 1/24/12, that dietary staff " just serves the meal " and does not feel that she was given a choice of foods at meal times. R46 reported " would like to have a choice of food that she eats. " R46 had multiple diagnoses, including above the knee amputation, esophageal reflux, persistent mental disorder, and depressive disorder. An annual minimum data set (MDS) was	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 5	F 242		

completed on 8/3/11 and a quarterly MDS was done on 10/27/11. Both MDSs indicated R46 was cognitively intact with no signs or symptoms of delirium, psychosis or any behavioral issues. She had no communication barriers and was generally independent with eating after staff set up her meals.

R46 was again interviewed at 8:09 a.m. on 1/25/12. She was eating her breakfast and reported that she was not satisfied with breakfast served as food was cool. She Indicated that she would talk to dietary staff about this but no dietary staff were available.

R46 was interviewed again at 1:05 p.m. on 1/25/12. Resident was sitting at a table in the dining room with her noon meal in front of her. She was not eating and appeared upset. She reported that she did not like what was served. She indicated the carrots were cold and she did not like the pork patty. Again, she reported she would have told the dietary staff about this and requested an alternative, but no dietary staff was available.

An interview was completed with Dietary Aide (DA)-A, who reported an alternate was available to all residents if they do not like what was served for the main entrée. DA-A indicated the alternate was not posted and so residents do not know what the alternate would be. If a resident voices that they do not like the main entrée, dietary staff will request an alternate from the cook. DA-A reported that soup and sandwiches are always available to residents at their request.

An interview was completed with the Dietary

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 6	F 242		

Manager at 12:34 p.m. on 1/25/12. She reported that she was unaware of R56 ' s complaint of not having choices for meals. The DM did report R56 did have problems asserting herself at times and if she was dissatisfied with food served, may not say anything to staff. The DM reported that at the present time, the facility had a fairly passive population, who may not report any concerns they have. The DM did indicate that after the meal was served, dietary staff do not check with residents regarding their meal satisfaction and so she did verify that there would not be any dietary to tell if they did not like what was served.

An interview with registered nurse Clinical Manager (CM) C was completed at 1:15 p.m. on 1/25/12. CM-C reported that R56 had not voiced any complaints regarding not having choices for food or any dissatisfaction regarding food choices. CM-C did indicate that if R56 had any concerns, she would generally talk to her daughters, who would bring the issue to the nursing staff. CM-C reported " R56 does have a hard time voicing concerns. "

R28 was not provided the dietary plan requested by family members.

A telephone interview was completed at 11:25 a.m. on 1/24/12 with R28 ' s family-A, who reported that the family was very concerned regarding R28 ' s weight gain since admission to the facility. Family-A stated that R28 had gained 8 pounds in the recent past and she had talked to the facility ' s Dietary Manager about this. Family -A indicated they had requested R28 not receive any " sugary snacks " but the ' facility does not seem to get it ' and continues to provide sugary

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 7 snacks during snack pass. " Family-A stated she and her sister had requested R28 be given a piece of fruit at snack time. Family-A reported that her mother will eat whatever anyone gives her too eat and even if R28 was full, will eat it until it is gone. R28 had a current diagnosis that included dementia, carcinoma of unspecified part of intestine, abnormality of gait, atrial fibrillation and hypothyroidism. According to the significant change MDS, completed on 12/29/11, R28 had both long and short term memory issues and was severely cognitively impaired. She had problems understanding and making self understood at times. She needed extensive assistance of 2 facility staff for ADLs (activity of daily living) and needed limited assistance of one staff at mealtime. An interview was completed with the Dietary Manager (DM) at 12:34 p.m. on 1/25/12, who reported she was aware that family was very concerned regarding resident ' s weight gain. DM reported that she had negotiated with the family to put resident on " small portions " and since doing this, R28 had " lost a few pounds " . DM indicated she did not feel that it was " right to withhold sugary snacks " from R28 and reported she was under the impression the family was accepting of the small portions to R28 ' s diet and were willing to bypass the ' fruit only for snack ' request. The DM did report that R28 was unable to make personal choices regarding meal choices and ate whatever staff gave her. R25 did not receive an opportunity for choice at	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 8 snack times. During interview at 6:30 p.m. on 1/23/12, R25 stated "I get hungry in between meals. I'd like something that will tide me over - like a half sandwich or something-nothing sweet." At 2:15 p.m. on 1/25/12, R25 indicated she had told nursing staff she gets hungry between meals and she did not like sweets but she hasn't seen anything done about the report yet. R25 had multiple diagnoses including pyelonephritis and malaise/fatigue. The Minimum Data Set (MDS) dated 12/23/11 identified R25 as alert and oriented. An observation of the snack cart at 8:00 p.m. on 1/23/12 revealed cookies as the primary snack with substantial snacks of sandwiches provided to specific residents. The cart also contained juice. When asked at 2:00 p.m. on 1/26/12, Clinical Manager(CM) B indicated R25's request came up in care conference in 12/11. CM-B stated "We told her there's always sandwiches or snacks available, she just has to ask. There's always sandwiches on the cart and I wonder why she (R25) doesn't know that. Sometimes the kitchen has made special snacks for people - they would make one especially for the resident. I don't think we talked about just sending her up something - it just came up briefly." An interview at 9:30 a.m. on 1/26/12 with the Dietary Manager (DM) was completed. The DM reported she was unaware of the R25's request. The DM also stated "They (the residents) just	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 9 need to ask." R67 did not receive an opportunity for choice at meal times. R67 had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11 R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room, according to the Director of Nursing (DON) during an interview at 1:30 p.m. on 1/26/12. At 9:00 a.m. on 1/25/12, R67 received her breakfast tray from staff of scrambled eggs, cereal and yogurt. Staff left room after setting up R67's tray. There was no offer of choice prior to the staff member leaving the room. R67 indicated she was "so tired of eggs". R67 clarified she "will eat a soft egg - like a fried egg - but sick of scrambled eggs. I got them every morning for 5 months at my previous place. That was a nice place - you could choose what you wanted to eat." When asked if she got choices with her meals now, R67 stated "No, not at all. You get what you get." According to Clinical Manager (CM) C at 10:30 a.m. on 1/26/12 , "(R67) is informed at care conferences and resident council to ask for something different if she doesn't like it. There's always second choices-she has asked for something different when she doesn't like it." R67 stated at 10:50 a.m. on 1/26/12 "I've been in	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 10 this room a long time. There's not always someone to tell if I don't like it." R67 further stated she was "not fussy but it would be kind of nice to have some options." R56 was not offered an opportunity for choice at meal times. Upon interview at 10:10 a.m. on 1/24/12, R56 indicated there was no choice for meal selection at meal time. She stated "When I don't like it, you're stuck with it." R56 had multiple diagnoses including Diabetes and Glaucoma. R56 was assessed by staff as alert and oriented with minor forgetfulness according to progress notes. Observation of the lunch meal in the north dining room on 1/25/12 revealed R56 did not eat her meat. There was no staff available in the dining room for residents to ask for an alternate selection. An interview with R56 at 1:50 p.m. on 1/25/12 indicated "I don't care for pork. I thought it was fish. I only had a bite. I didn't care for it. They didn't offer me anything else. I just ate the potatoes. They never ask (if I would like something different)." Interview with the Dietary Manager (DM) at 9:30 a.m. on 1/26/12 indicated "(R56) had never told me she didn't like pork." The DM indicated residents need to indicate they do not like something in order to get something different. When asked how resident's were supposed to report it when there was no staff available in the dining room to tell, the DM stated "Good point - there are no staff to tell if they don't like the food	F 242		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 11 served." The DM also indicated that residents can review the posted menu on their way through the door and if they don't like something just let someone know and they will provide a substitute prior to the resident's food being served. When asked how resident's can review the menu if they are unable to visualize the menu or can't read the DM again stated "residents can tell staff they don't like the food being served and they would be offered something else." "We always have leftovers available in the freezer or soup and sandwich available." When interviewed at 2:20 p.m. on 1/26/12, Clinical Manager(CM) B indicated she was unaware R56 was having an issue with choices at meal time. "She's pretty good about making her needs known."	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 12 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess risk and interventions to minimize the risk for pressure ulcer development and worsening of pressure ulcers for 1 of 3 residents (R113) reviewed for pressure ulcers and related to wheelchair positioning needs for 1 of 3 residents (R93) reviewed in the sample for positioning. Findings include: R113 was admitted on 11/25/11 with a stage I pressure ulcer on his coccyx, which developed into two stage II pressure ulcers 12/18/11 and 12/20/11.	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 13 R113 had diagnoses that included urinary retention, fatigue, severely under weight, advanced dementia with depression and anxiety, and a history of infection. The admission minimum data set (MDS) dated 12/2/11, identified R113 was cognitively intact, no behavioral concerns, and required extensive assistance of one staff for repositioning. The MDS indicated R113 was at high risk for pressure ulcer development and did not have one or more unhealed pressure ulcers at a stage I or higher. The MDS revealed skin and ulcer treatments included a pressure reducing device for his chair and bed, a turning and repositioning program, and ointments/medication application to his body (not his feet). The admission initial nursing data form, dated 11/25/11, identified R113 had a reddened coccyx and identified that a tissue tolerance test was to be completed. R113's tissue tolerance observation for the lying position, dated 11/25/11, identified redness on his coccyx after lying for two hours. The observation form then instructed staff to re-observe after one and a half hours. The observation form asked after one hour was the redness noted over the boney prominences which the facility identified as "Yes, the area remained red, initiate wound care protocols stage I and redo the observation at 1 hour." R113's tissue tolerance for sitting observation dated 11/25/12 read "Unable to assess - resident in lying position through-out shift." The facility did not initiate wound care protocols for a stage I pressure ulcer to monitor	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 14 the area and did not assess R113 for tissue tolerance while sitting to determine appropriate interventions for repositioning needs. A tissue tolerance skin risk factor evaluation form, dated 12/1/11, noted R113 was at mild risk for skin breakdown. It identified he had a bio foam mattress and pressure redistribution cushion in his wheelchair. It noted he "has a reddened coccyx which was present upon admit" and to apply barrier cream to this area twice daily. On 12/18/11, a weekly wound documentation form was initiated for a stage II pressure ulcer on R113's coccyx. The form indicated R113 had a stage II pressure ulcer on his coccyx measuring 1.5 cm by 1.5 cm by 0.2 cm, with no draining or odor. The treatment included an Allevyn foam dressing and Tena with Zinc. On 12/23/11 the wound was noted to be stable, and was reassessed as a stage II pressure ulcer measuring 0.2 cm by 0.1 cm by 0.1 cm, with the same treatment. On 12/30/11 the wound was noted to be improving, and was reassessed as a stage II pressure are measuring 0.4 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/8/12 the wound was noted as stable and was reassessed as a stage II pressure are measuring 0.6 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/17/12 the area was assessed by the wound care practitioner. On 12/20/11 a weekly wound documentation form was initiated for a stage II pressure ulcer identified on the diagram as located on the lower area of the buttock and noted as a "lower open area." The form indicated R113 had a stage II pressure ulcer on his lower buttock measuring	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 15 1.8 cm by 1.2 cm by 0.1 cm, with no draining or odor. The treatment included an Duoderm dressing. On 12/25/11 the wound was reassessed as a stage II pressure ulcer measuring 0.2 cm by 1.5 cm with no depth with 100% granulation. At this time an Allevyn foam dressing and Tena with Zinc treatment was applied and the area was noted as improved. On 1/24/12 the wound was reassessed as a stage II pressure area measuring 0.3 cm by 0.2 cm with no depth, the area was noted as dry, the treatment was changed to Mepilex Boarder and was identified as improved. On 1/17/12 the area was assessed by the wound care practitioner. No further documentation was provided to indicate that the area was monitored or assessed from 12/25/11 to 1/17/12. The physician orders and progress notes form dated 1/17/12 identified a wound care consult was completed. The note indicted R113 had stage II skin breakdown on his sacrococcygeal area for approximately two weeks. The note identified R113 was very thin in stature with a weight of 120 pounds on admit, with an approximate eight to ten pound weight loss since then. It noted R113 laid down after breakfast and lunch, used a wheelchair for locomotion, had a foam cushion, and did not elevate the head of his bed. It identified R113 was turned every two hours but turns self back to supine and has an alternating air mattress. The note indicated on exam the coccyx ulcer measured 0.5 cm by 0.5 cm and the right sacral ulcer measured 2 cm x 1 cm; both stage II with scant exudates. The practitioner instructed to continue with the alternate air mattress overlay, lay down every two hours twice a day, try to alternate sides, and	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 16 apply Mepilex Boarder four by four dressing to coccyx ulcer in a diamond shape, change every other day. Wound care was completed on 1/25/12 and was not due until 1/27/12. At 9:45 a.m. on 1/26/12 this surveyor requested to observe R113 wound and dressing change. Wound care for R 113 was observed at 10:12 a.m. on 1/26/11 and the Mepilex Boarder dressing was not applied to wound. Nursing assistant (NA)-A verified the dressing came off that morning during morning cares. NA-A confirmed she reported that information to registered nurse (RN)-A. R113 was observed to be very thin and his coccyx protruded. The wound was approximately 0.3 by 0.2 with superficial depth. The surrounding skin appeared red and dry. CM-A reported the area was not warm to the touch and confirmed the area had some dry, flaking skin. CM-A applied a Zinc ointment and a Mepilex Boarder dressing to the area in the shape of a diamond. During interview at 10:32 a.m. on 1/26/11, RN-B stated she took over for RN-A at 9:30 a.m. and it was not passed on in report that R113's dressing came off during morning cares. During interview at 10:34 a.m. on 1/26/12 clinical manager (CM)-B verified the dressing should have been re-applied if it had fallen off. CM-B stated she expected that information to be passed on in report. CM-B verified the tissue tolerance was not completed and and should have been to determine appropriate timely repositioning intervention. CM-B confirmed the the tracking of the wounds were to be done weekly and that this was not completed for each	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 17 identified pressure area. CM-B verified during the dressing change the surround area where the Zinc ointment and Mepilex Boarder dressing was applied was dry and verified that these treatments were intended to dry out moist wounds. CM-B stated the wound appeared drier than when she last applied the treatment but did not find this concerning enough to consult with the practitioner to readdress if the current treatment was appropriate to promote healing of the wound. During follow-up interview at 10:48 a.m. on 1/26/12 NA-A stated the staff were expected to place a pillow behind R113's back when repositioning him side to side. NA-A stated R113 frequently moved himself back onto his back. During interview at 11:03 a.m. on 1/26/12, NA-D stated it was not her practice to place a pillow behind R113's back when turning him side to side. The Pressure Ulcer Risk Policy dated 9/11 indicated regardless of the residents total risk score each risk factor and potential causes should be reviewed individually. It instructed to implement interventions according to the Braden score and/or residents individual risk factors identified. Wheelchair assessment R93 had multiple diagnoses including cerebral vascular accident (CVA). R93 was assessed by facility staff to be alert and oriented according to the most recent care	F 272		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 18 conference review, dated 12/8/11. A review of the MDS (Minimum Data Set) and CAA (Care Area Assessment) dated 6/16/11, revealed no assessment for wheelchair positioning. Review of all assessments completed since 6/11 revealed no assessments were completed for wheelchair positioning. Review of the quarterly care conference documentation dated 12/8/11, 9/14/11, and 6/23/11 revealed wheelchair positioning had never been addressed. On 1/23/12 at 7:30 p.m. and 1/25/12 at 8:00 a.m., R93 was observed to be slouched forward in the wheelchair. Observation on 1/25/12 at 2:00 p.m. revealed only minor changes in his positioning in the wheelchair. When asked, R93 was unable to position himself correctly in the w/c. At that time R93 was asked about his comfort level in the wheelchair. He stated "It's not the best in the west." R93 continued to say it would be better if he could "sit up a little bit better." Review of R93's record revealed no progress notes from therapy or nursing identifying the problem of wheelchair positioning. Interview with Clinical Manager-B (CM-B) indicated she was aware of his positioning issues with the wheelchair. "(R93) has always been a sloucher. I assumed he was comfortable. He never said anything to me." CM-B admitted she had never asked R93 about his wheelchair, but "I'll talk to him about it."	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 19 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record observation, interview and document review, the facility failed to develop a comprehensive care plan related to contact precautions for 1 of 1 residents (R67) in the sample reviewed for infection control protocols. Findings include: R67 did not have a comprehensive care plan related to infection control precautions. R67 had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11, R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that causes infectious diarrhea as well as more	F 279		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 20 serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room since this date, according to the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12. During observations of care at 8:00 a.m. on 1/25/12, R67 was observed in a private room. Nursing assistant (NA)-A was observed to gown and glove prior to entering the room and indicated R67 was in isolation due to a c-diff infection. Review of the care plan identified the problem of R67's c-diff infection. The problem was initiated 1/11/12. The goal was for the resident to have no complications related to the infection. The care plan identified multiple interventions including to monitor the resident, education and disinfecting equipment used before it leaves the room. The care plan failed to identify the contact precautions, if the resident could leave the room and if so what needed to be done prior to the resident leaving the room, at what point the isolation precautions could be lifted, and what psychosocial things were going to be done while R67 was required to stay in her room. Clinical Manager (CM)-C stated at 10:20 a.m. on 1/26/12, the DON wrote R67's care plan. At 10:50 a.m. on 1/26/12 the DON stated "This was new to us [treating C-diff] so we're really working hard to get it right." After review of the assessment of R67's progress at 1:30 p.m. on 1/26/12, she stated "I guess I didn't add it to the actual care plan. I believe it was included [contact precautions] on the aide sheet." When the aide sheet was reviewed together, it failed to identify	F 279		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 21 contact precautions but did identify the c-diff infection.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident's plan of care was revised as appropriate related to fall risk for 1 of 3 residents (R56) reviewed in the sample for accidents and related to an unavoidable sensory decline in vision for 1 of 1 residents (R56) reviewed in the sample for sensory problems.	F 280		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22 Findings include: R56 did not have her care plan revised to minimize the risk of further falls following a fall. In addition, the care plan was not revised according to R56's current visual limitations or to assist with maintaining or improving her independence as it related to a decline in vision. R56 had multiple diagnoses including transient ischemic attacks (TIA's), glaucoma and diabetes. An annual minimum data set (MDS) completed on 8/3/11 and the quarterly MDS completed on 10/26/11, indicated R56 was cognitively intact with no signs or symptoms of psychosis. R56 also had no behavioral issues. The MDSs noted R56 had visual impairments but was able to read large print and was able to feed herself meals after the staff "set up" the meal. The MDSs also indicated that R56 had no history of falls. According to progress notes from 8/23/11 through 1/25/12, R56 is alert and oriented with minor forgetfulness. The forgetfulness increased with urinary tract infections (UTI's). R56 had a fall from bed at 1:45 a.m. on 1/20/12. According to the incident report and progress note from the fall, R56 stated she fell while trying to get up to go to the bathroom. R56 was being actively treated for a UTI at the time of the fall. Although R56 fell on 1/20/12, there were no interventions put in place to minimize the risk of further falls until 1/24/12. In the area of the incident report directing staff to	F 280		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23	F 280		

document immediate interventions implemented, a low bed was identified by the LPN completing the report. However, R56 was already in a low bed at the time of the fall.

When asked about the delay in interventions at 3:15 p.m. on 1/24/12, Clinical Manager (CM) B indicated she received the report on 1/23/12. After review, she had further investigation to do before bringing it to the interdisciplinary team (IDTeam) for review. On 1/24/12 CM-B was able to bring the incident report forward to the IDTeam. At that time the team decided to implement a sensor pad alarm which would trigger the call light should R56 attempt to get up from bed independently. CM-B verified the above findings were accurate. When asked what was expected of the floor nurses when the incident occurred, CM-B indicated that the incident should be reviewed by the nurse with appropriate interventions implemented at the time of the incident. CM-B confirmed that the low bed was already in place at the time of the incident.

Although a Fall Risk Evaluation had been completed on 1/24/12, it failed to identify R56's significant visual limitations and her acute UTI at the time of the fall.

R56 was interviewed at 10:10 a.m. on 1/24/12. She indicated her vision had significantly declined in "the past few months." She further reported that at her last ophthalmology appointment "they (the physician) call me legally blind." R56 further stated she "used to" be able to make out the headlines and pictures in the newspaper, but she can no longer do that unless the headlines are "really big." R56 stated "They don't give me a lot

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 24 of help at meals. I have a hard time feeding myself - getting the food on the fork and getting it to my mouth.' On 1/25/ 12 at 1:30 p.m. Nursing Assistant (NA) C indicated he was aware of R56's visual limitations. He stated "I ask her how she's doing and she always talks about - I'm losing my vision - I can't see that kind of thing." When interviewed at 1:15 p.m. on 1/26/12, Clinical Manager (CM) B indicated she was unaware R56 had significant limitations in her vision. She reported the first time she was aware of the limitation was "yesterday in care conference." She further indicated that after discussion at the care conference, "dietary is going to get her a dark plate so she can see her food better. Part of what we talked about yesterday was to have dietary (staff) explain food and use clock method when the food is provided to her." The current plan of care identified visual limitations on 8/18/11. The goal was to maintain her ability to read large print through the review date of 2/2/12. R56 was no longer able to read most headlines in the newspaper. Further, according to the interview on 1/24/12 at 10:10 a.m. R56 struggled to eat independently, could no longer see to pick out her clothing and could make out large objects within her environment but was unable to determine what those objects were in most cases. R56's care plan failed to be revised with appropriate interventions to assist with the identified decline in vision.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 25 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure each resident received care and services in accordance with their plan of care, related to refusal of pressure ulcer interventions for 1 of 4 residents (R91) reviewed in the sample for pressure ulcer. Findings include: R91 did not receive the pressure ulcer education as directed by her current plan of care dated as revised on 12/5/11. R91 had multiple diagnoses including multiple sclerosis (MS). An interview with case manager (CM)-B at 7:30 p.m. on 1/23/12 was completed and reported R91 was alert and oriented and currently had a stage II (partial thickness) pressure ulcer on her bottom which was a recurring problem. According to the interview with CM-B, R91 "heals up then opens up again and she's resistive with off loading." R91's current plan of care directed staff to "provide hourly off loading and repositioning as (R91) allows," "encourage (R91) to lay in bed or recliner between meals and activities," and "tilt	F 282		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 26 wheelchair (w/c) slightly back for pressure relief." The care plan also indicated "Know (R91) is resistive with repositioning, especially at night." The care plan directed staff to educate (R91) on the causes of breakdown including: transfer/position requirements, importance of taking care during ambulating/mobility, good nutrition and repositioning." During observations on 1/25/12-day shift, R91 was observed to not lay down from 7:10 a.m. until 2:25 p.m. This observation was confirmed by R91 as she stated "I'm busy." An interview with nursing assistant (NA)-B at 6:40 a.m. on 1/26/12 indicated R91's buttocks has "been like this forever" and verified R91 is resistive to most interventions but staff continued to offer. At 6:40 a.m. on 1/26/12, R91 stated "there's three nurses on me all the time" regarding interventions but R91 was unable to communicate consequences of refusals. During interview regarding the intervention of education regarding pressure ulcers at 2:10 p.m. 1/16/12, CM-B indicated "I know I haven't done a risk benefit (review of refusal of pressure ulcer interventions) with her on this. We've had conversations about the refusals but I don't know if I documented it." Review of R91's medical record revealed no documentation of education provided to R91 related to pressure ulcer prevention, development, interventions and consequences of refusals.	F 282		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure each resident received the necessary care and services related to wheelchair positioning for 1 of 3 residents (R93) reviewed in the sample for positioning. Findings include: R93 did not receive assistance with the identified problem of wheelchair positioning. R93 had multiple diagnoses including cerebral Vascular Accident (CVA). R93 was assessed by facility staff to be alert and oriented according to the most recent care conference review, dated 12/8/11. Although R93 has been seen by Occupational Therapy in the past, R93 had never been seen by therapy for wheelchair positioning. At 7:30 p.m. on 1/23/12 and 8:00 a.m. on 1/25/12, R93 was observed to be slouched forward with pelvis pushed forward in wheelchair and a large gap between his back and the back of the wheelchair. In addition his pelvis was somewhat twisted in the chair with his left hip tight against	F 309		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 28 the side of the wheelchair. Upon request at 7:30 p.m. on 1/23/12, R93 could independently adjust himself in the wheelchair, however he was unable to get his pelvis back and centered in the wheelchair. An interview with R93 was completed at 8:00 a.m. on 1/25/12 and was asked about his comfort level in the wheelchair. He stated "It's not the best in the west." R93 continued to report "it would be better if he could sit up a little bit better". When asked what he would like done differently about his wheelchair, he commented he thought a "little bigger chair" would be helpful. R93 indicated he would be receptive to assistance with wheelchair positioning as it would be "a little easier to sit in all day." Review of R93's record revealed no progress notes from therapy or nursing identifying the problem of wheelchair positioning. Interview with Clinical Manager (CM)-B indicated she was aware of his positioning issues with the wheelchair. "(R93) has always been a sloucher. I assumed he was comfortable. He never said anything to me." CM-B admitted she had never asked R93 about his wheelchair, but "I'll talk to him about it."	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 29	F 311		

by:
Based on observation, interview and document review, the facility failed to ensure each resident was provided with appropriate treatment and services to maintain or improve their abilities related to an unavoidable sensory decline in vision for 1 of 1 residents (R56) reviewed in the sample for sensory problems.

Findings include:

R56 had a significant decline in vision without intervention.

R56 had multiple diagnoses including glaucoma, diabetes, and diabetic retinopathy.

The care area assessment (CAA) for vision, dated 8/17/11, indicated R56 had impaired vision due to difficulty reading regular print but was able to read large print and see objects in the environment. The assessment failed to include the diagnoses of glaucoma, history of cataracts or transient ischemic attack (TIA), both of which could contribute to a visual decline.

The most current nutrition assessment completed 11/2/11, identified R56 as sighted with no problems feeding self.

The current care plan, revised 11/11, identified impaired vision. The established goal was to maintain the ability to read large print. The approaches included "Monitor/document/report to MD the following signs/symptoms of acute eye problems: Change inability to perform ADL's (Activities of Daily Living), decline in mobility, sudden visual loss, pupils dilated, gray, or milky,

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 30	F 311		

complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision." The care plan did not identify any assistive devices for improving her vision or assisting R56 to maintain her independence.

R56 had ophthalmology visits on 5/17/11 and 11/17/11. She was identified with open angle glaucoma in both eyes and pseudophakia in both eyes. The physician noted the onset to be gradual and no change in treatment was recommended.

R56 was interviewed at 10:10 a.m. on 1/24/11, her vision had significantly declined in "the past few months." She further indicated that at her last ophthalmology appointment "they [physician]call me legally blind." She reported to" be able to make out the headlines and pictures in the newspaper, but she can no longer do that unless the headlines are "really big." R56 stated "They [facility staff] don't give me a lot of help at meals. I have a hard time feeding myself - getting the food on the fork and getting it to my mouth.' When asked if she's talked with therapy about her problems maintaining independence at meals or if any adaptive equipment had been offered, R56 stated "No, they've never given me anything like that."

During an interview at 1:50 p.m. on 1/25/12 , R56 verbalized that wanted to make certain staff understood she wanted to remain as independent as possible and stated "I like to be independent. I just really want to do things for myself as much as I can. I don't want everyone to know I can't see. The aides know - they pick out my clothes for me in the morning."

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 31 On 1/25/ 12 at 1:30 p.m., nursing assistant (NA) -C indicated he was aware of her visual limitations. He stated "I ask her how she's doing and she always talks about losing her vision" and that she "can't see" When interviewed at 1:15 p.m. on 1/26/12, Clinical Manager (CM)-B indicated she was unaware R56 had significant limitations in her vision. She indicated the first time she was aware of it was "yesterday in care conference." She further indicated that after discussion "Dietary is going to get her a dark plate so she can see her food better. I should make her an eye appointment to get her vision checked. I wasn't aware her sight was that bad. Her last ophthalmology appointment was 11/17/11 - there was nothing specific about visual ability. Part of what we talked about yesterday was to have dietary explain food and use clock method when the food is provided to her."	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 32 review the facility failed to monitor and provide treatment to minimize the risk and promote healing of pressure ulcers for 1 of 3 residents (R113) reviewed for pressure ulcers and related to education including risks and benefits for 1 of 3 residents (R91) reviewed in the sample with a recurrent pressure ulcer. Findings include: R113 was admitted on 11/25/11 with a stage I pressure ulcer on his coccyx which developed into two stage II pressure ulcers on12/18/11 and 12/20/11. R113 had diagnoses that included urinary retention, fatigue, severely under weight, advanced dementia with depression and anxiety, and a history of infection. The admission minimum data set (MDS) dated 12/2/11 identified R113 had no cognitive impairments, no behaviors, and required extensive assistance of one staff for repositioning. The MDS indicated R113 was at high risk for pressure ulcer development and did not have one or more unhealed pressure ulcers at a stage I or higher. The MDS revealed skin and ulcer treatments included a pressure reducing device for his chair and bed, a turning and repositioning program, and application of ointments/medication other than to his feet. The admission initial nursing data form dated 11/25/11 identified R113 had a reddened coccyx and a tissue tolerance was to be completed. R113's tissue tolerance observation for the lying	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 33 position dated 11/25/11 identified staff observed his current skin integrity after two hours and redness was noted on his coccyx. The observation form then instructed staff to re-observe after one and a half hours. The observation form asked after one hour was the redness noted over the boy prominence's which the facility identified as "Yes, the area remained red, initiate wound care protocols stage I and redo the observation at 1 hour." R113's tissue tolerance for sitting observation dated 11/25/12 read "Unable to assess - resident in lying positioning through-out shift." The facility did not initiate wound care protocols for a stage I pressure ulcer to monitor the area and did not assess R113 for tissue tolerance while sitting to determine appropriate interventions for repositioning needs. A tissue tolerance skin risk factor evaluation form dated 12/1/11 noted R113 was at mild risk for skin breakdown. It identified he had a bio foam mattress and pressure redistribution cushion in wheelchair. It noted he "has a reddened coccyx which was present upon admit" and to apply barrier cream to this area twice daily. R113's plan of care, dated 12/13/11, identified he had a stage I pressure ulcer on his coccyx related to immobility and low body weight. The interventions included the application of barrier cream to his coccyx and that he was turned and repositioned throughout the day and repositioned during routine rounds on the night shift. It also identified he was to utilize a biofoam mattress and pressure redistribution cushion in his wheelchair. On 12/18/12 the care plan was updated to include an air mattress overly to the	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34 bed. On 12/18/11, a weekly wound documentation form was initiated for a stage II pressure ulcer on R113's coccyx. The form indicated R113 had a stage II pressure ulcer on his coccyx measuring 1.5 cm by 1.5 cm by 0.2 cm, with no draining or odor. The treatment included an Allevyn foam dressing and Tena with Zinc. On 12/23/11 the wound was noted to be stable, and was reassessed as a stage II pressure ulcer measuring 0.2 cm by 0.1 cm by 0.1 cm, with the same treatment. On 12/30/11 the wound was noted to be improving, and was reassessed as a stage II pressure are measuring 0.4 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/8/12 the wound was noted as stable and was reassessed as a stage II pressure are measuring 0.6 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/17/12 the area was assessed by the wound care practitioner. On 12/20/11, a weekly wound documentation form was initiated for a stage II pressure ulcer identified on the diagram as located on the lower area of the buttock and noted as a "lower open area." The form indicated R113 had a stage II pressure ulcer on his lower buttock measuring 1.8 cm by 1.2 cm by 0.1 cm, with no draining or odor. The treatment included an Duoderm dressing. On 12/25/11 the wound was reassessed as a stage II pressure ulcer measuring 0.2 cm by 1.5 cm with no depth with 100% granulation. At this time an Allevyn foam dressing and Tena with Zinc treatment was applied and the area was noted as improved. On 1/24/12 the wound was reassessed as a stage II pressure area measuring 0.3 cm by 0.2 cm with	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35 no depth, the area was noted as dry, the treatment was changed to Mepilex Boarder and was identified as improved. On 1/17/12 the area was assessed by the wound care practitioner. No further documentation was provided to indicate that the area was monitored or assessed from 12/25/11 to 1/17/12. The physician orders and progress notes form dated 1/17/12 identified a wound care consult was completed. The note indicted R113 had stage II skin breakdown on his sacrocoxygeal area for approximately two weeks. The note identified R113 was very thin in stature with a weight of 120 pounds on admit, with an approximate eight to ten pound weight loss since then. It noted R113 laid down after breakfast and lunch, used a wheelchair for locomotion, had a foam cushion, and did not elevate the head of his bed. It identified R113 was turned every two hours but turns self back to supine and has an alternating air mattress. The note indicated on exam the coccyx ulcer measured 0.5 cm by 0.5 cm and the right sacral ulcer measured 2 cm x 1 cm; both stage II with scant exudates. The practitioner instructed staff to continue with the alternate air mattress overlay, lay down every two hours twice a day, try to alternate sides, and apply Mepilex Boarder four by four dressing to coccyx ulcer in a diamond shape, and to change this dressing every other day. Wound care was completed on 1/25/12 and was not due until 1/27/12. At 9:45 a.m. on 1/26/12, this surveyor requested to observe R113 wound and dressing change. Wound care for R113 was observed at 10:12 a.m. on 1/26/11 and the Mepilex Boarder dressing was not applied to	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 36 wound. Nursing assistant (NA)-A verified the dressing came off that morning during morning cares. NA-A confirmed she reported that information to registered nurse (RN)-A. R113 was observed to be very thin and his coccyx protruded while his buttock tissue appeared to sag and sink in giving the appearance of no buttock. The wound was approximately 0.3 by 0.2 with superficial depth. The surrounding skin appeared red and dry. CM-A reported the area was not warm to the touch and confirmed the area had some dry, flaking skin. CM-A applied a Zinc ointment and a Mepilex Boarder dressing to the area in the shape of a diamond. During interview at 10:32 a.m. on 1/26/11 RN-B stated she took over for RN-A at 9:30 a.m. and it was not passed on in report that R113's dressing came off during morning cares. During interview at 10:34 a.m. on 1/26/12, clinical manager (CM)-B verified the dressing should have been re-applied if it had fallen off. CM-B stated she expected that information to be passed on in report. CM-B verified the tissue tolerance was not completed and should have been used to determine appropriate timely repositioning intervention. CM-B confirmed the tracking of the wounds were to be done weekly and this, was not completed for each identified pressure area. CM-B verified during the dressing change, the surrounding area where the Zinc ointment and Mepilex Boarder dressing was applied was dry and verified that these treatments were intended to dry out moist wounds. CM-B stated the wound appeared drier then when she last applied the treatment but did not find this concerning enough to consult with the practitioner	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 37 to readdress if the current treatment was appropriate to promote healing of the wound. During follow-up interview at 10:48 a.m. on 1/26/12, NA-A stated the staff were expected to place a pillow behind R 113's back when repositioning him side to side. NA-A stated R113 frequently moved himself back onto his back. During interview at 11:03 a.m. on 1/26/12 NA-D stated it was not her practice to place a pillow behind R113's back when turning him side to side. The Pressure Ulcer Risk Policy, dated 9/11, indicated regardless of the residents total risk score each risk factor and potential causes should be reviewed individually. The policy also instructed staff to implement interventions according to the Braden score and/or resident's individual risk factors that were identified. R91 did not receive the services to promote healing and minimize the risk for development of pressure ulcers. R91 had multiple diagnoses including Multiple Sclerosis (MS). The Braden Scale Pressure Ulcer Risk Assessment, dated 12/1/11, identified R91 to be at mild risk for pressure ulcer development. The most recent tissue tolerance review completed by the facility in 11/11, identified the need for hourly off loading and repositioning had been initiated. The care plan dated as revised on 12/5/11 identified recurrent pressure ulcers as a problem and identified resident resistance to off loading but staff was to continue to offer and educate the	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 38 resident. An interview with CM-B at 7:30 p.m. on 1/23/12, revealed R91 currently had a stage II (partial thickness) pressure ulcer to her buttocks, which is a recurring problem. "She heals up, then it opens up again - she's resistive with off loading." Observation during interview at 7:00 p.m. on 1/23/12, revealed R91 leaned all the way back in her recliner. Throughout the 20 minute observation, R91 made no attempt to shift position in the recliner and indicated staff assisted her with repositioning as needed. During observations on 1/25/12 day shift, R91 was observed to not lay down from 7:10 a.m. until 2:25 p.m. This observation was confirmed by R91 as she stated "I'm busy." An interview with NA-B at 6:40 a.m. on 1/26/12, indicated R91's buttocks has "been like this forever" and verified R91 was resistive to most interventions but staff continued to offer. An observation at 6:40 a.m. on 1/26/12, revealed R91's pressure ulcer was on the left buttock fold and scabbed over with a macerated peri wound surrounding the scabbed area. There were multiple deep indentations from the bedding in her buttocks, back and legs. R91 and NA-B indicated she preferred not to reposition during the night shift as it disrupted her sleep. Although R91 consistently refused pressure ulcer interventions, staff was aware of the refusals, and the plan of care directed staff to educate her on pressure ulcers, there was no evidence of this	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 39 education in the resident record. When asked at 6:40 a.m. on 1/26/12, R91 stated "there's 3 nurses on me all the time" regarding interventions but was unable to communicate consequences of refusals. During interview regarding the intervention of education for pressure ulcers on at 2:10 p.m. on 1/16/12, CM-B indicated "I know - I haven't done a risk benefit (review of refusal of pressure ulcer interventions) with her on this. We've had conversations about the refusals but I don't know if I documented it." Documentation on the "Weekly Wound Documentation Form" on 1/8/12 identified a stage II (partial thickness) pressure ulcer on the right gluteal fold, which was pink in color with no drainage. The ulcer measured 0.9 cm x 1.5 cm and staff indicated barrier cream was applied. On 1/11/12 the form identified "no change" and indicated the ulcer measured 0.9 cm x 1.4 cm. Staff indicated on 1/15/12, the stage II pressure ulcer measured 0.9 cm x 1.7 cm and had 100% granulation (healthy) tissue with moderate drainage. The note further identified the ulcer was larger in size and had declined. On 1/18/12, the flow sheet identified the ulcer had improved and measured 0.9 cm x 0.9 cm. The flow sheet further indicated the pressure ulcer had scabbed over and staff continued to use barrier cream. The flow sheet indicated on 1/25/12 that there was no drainage and the pressure ulcer measured 0.7 cm x 0.8 cm and had scabbed over. At 8:00 a.m. on 1/26/12, NA-B informed the nurse that when she was providing care to R91's bottom, the "scab came off" her buttocks and there was no longer an open area. The most	F 314		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 40 recent previous pressure ulcer was documented in progress notes as healed on 11/27/11. The pressure ulcer was identified to her coccyx and was first observed on 11/21/11.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely interventions to minimize the risk of falls for 1 of 3 residents (R56) reviewed in the sample for accidents. Findings include: R56 had a fall which was not reviewed in order to ensure adequate safety interventions for 4 days. R56 had multiple diagnoses including transient ischemic attacks (TIA's), glaucoma, and was currently being treated for a urinary tract infection (UTI). According to consistent daily progress notes, R56 was assessed by the facility to be alert and oriented with forgetfulness which was worse when R56 had a UTI.	F 323		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 41 The Fall Risk Evaluation completed 8/3/11, identified R56 to be at low risk for falls. The evaluation identified "will self transfer at times, forgetful, doesn't know limitations, extensive assist with transfers, doesn't always remember to use call light, raised edge mattress in place." The care plan initiated 8/18/11, identified limited physical mobility with a goal to "remain free from falls through the review date." The goal had been reviewed with an updated review date of 2/2/12. The care plan contained multiple interventions to maintain mobility and the safety interventions were "Raised edge mattress in place to orient her to bed parameters. Keep bed in lowest position to prevent injury. Reminder sign in place to remind (R56) to use call light and wait for assist. Provide verbal reminders of call light use with each application." R56 had a fall on 1/20/12 at 1:45 a.m. According to the incident report and progress notes for this date and time, R56 was attempting to get up and go to the bathroom. R56 got up from the window side of the bed and was found sitting on buttocks by bed. R56 normally gets up from bed on the side nearest the bathroom. The call light was within reach but was not used. In the section for immediate interventions following the fall, the completing LPN indicated "low bed" which was already in place at the time of the fall. This fall was not reviewed by the interdisciplinary team with interventions implemented until 1/24/12. According to Clinical Manager(CM)-B at 3:15 p.m. on 1/24/12, "Whoever the floor nurse is fills out the incident report and notifies family and	F 323		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 42	F 323		

physician. Then the incident reports go to the nurse manager and we discuss it in morning meetings, figure out interventions or we further investigate. Thursdays are the safety meeting. Therapy is not always at safety meeting but can call them and have them come down for a specific resident. We review all falls and interventions we put in place. If interventions are effective we close the incident report. If they're not effective or we have more to do, we leave the report open and continue to re-evaluate until we feel we came to a good solution." With regard to falls on Friday night or over the weekend, CM-B indicated "The nurse managers are on call but if there's nothing alarming, we review it Monday morning. We try and check in on the week end. They usually call us but sometimes they don't, so we call and check in and we may review it then." When asked why this fall waited for 4 days to be reviewed and have interventions put in place for safety, CM-B indicated that she had some questions regarding the fall and had to investigate on 1/23/12. She further stated that once her investigation was completed, she was able to review it with the interdisciplinary team on 1/24/12. CM-B indicated "We're going to put a bed sensor pad on her bed which will trigger her call light if she gets up. (R56) is a little more forgetful - she got up on window side of the bed instead of the door side. In this case it did wait until Tuesday for intervention because it took me awhile to finish up the investigation." CM-B verified that R56 is " a little more confused" at night.

The Fall Risk Evaluation dated 1/24/12, after the fall, identified R56 remained a low risk for falls. It should be noted that R56 was being treated for a

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 43 UTI at the time of the fall, which was not included in the evaluation. Further, the evaluation failed to include R56's significant visual limitations - indicating only that her vision was "impaired - sees large print, but not regular print in newspapers/books." The bed sensor was observed to be added to R56's bed on 1/24/12 and had been added to the care plan. However, the care sheet utilized by the nursing assistants failed to include the addition of the sensory pad to the bed. During an interview with R56 at 10:25 a.m. on 1/24/12, R56 indicated she "forgot" to use the call light the night of the fall. She further indicated she's been having problems with incontinence, but the problem is improving since working with therapy on it. She further stated "when you gotta go, you gotta go" and she just wanted to get to the bathroom. "I hate to wet myself."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 44 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received appropriate monitoring of medication for 1 of 10 resident (R91) in the sample reviewed for unnecessary medications. Findings include: An observation of medication administration at 12:25 p.m. on 1/25/12 revealed 91's pulse was not taken prior to the administration of Lanoxin (Digoxin-a cardiac medication) as ordered by her physician. R91 had multiple diagnoses including atrial fibrillation. She had a physician's order for Lanoxin (digoxin) 0.25 mg by mouth every day and according to the facility's standing orders, which were also signed by her physician, staff were directed to not give this medication if R91's pulse was less than 55 beats per minute. A review of the medication administration records (MAR's) revealed there was no pulse documented for the months of November, 2011, December, 2011 and January, 2012 There was	F 329		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 45 also no information on the MAR directing the facility staff to hold the digoxin for a pulse less than 55 or a prompt to take the pulse prior to administration. Interview with registered nurse (RN)-C at 8:15 a.m. on 1/26/12 revealed "I don't know why we don't take her pulse anymore. I'm thinking we used to but we don't do it anymore - but I don't know why. It's fallen off for a few residents where we used to do it and now we don't anymore." Clinical Manager (CM)-B at 8:30 a.m. on 1/26/12 verified the physician orders were accurate and the pulse should have been taken prior to administration of the digoxin.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal 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 legal 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 legal	F 334		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 46 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. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal 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 legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal 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. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or	F 334		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 47 the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents are offered and received education on immunizations for 1 of 6 residents (R115) reviewed in the sample for immunizations. Findings include: R115 did not receive education related to the influenza and pneumococcal vaccinations and therefore was unable to make an informed decision on whether or not to receive the immunizations. R115 was admitted 1/6/12 with diagnosis that included delirium related to surgery and anesthesia. Upon review of the medical record, on admission R115's grand-daughter assisted with the process due to R115's delirium and confusion. Physician orders for the pneumococcal and influenza vaccinations were signed by the physician on 1/17/12. R115 was offered the influenza and pneumococcal immunizations upon admission without evidence of the education being provided at that time. Due to the delirium, R115 was unable to give consent so his grand-daughter refused the vaccinations on behalf of R115. Although R115 returned to his baseline of	F 334		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 48 alertness and was oriented at the time of survey, R115 was not re-approached with education or provided an opportunity for the pneumococcal and influenza vaccinations. An interview with case manager (CM)-B at 2:00 p.m.on 1/26/12 verified the above information. She further indicated "I know she refused because he has never had it in the past and he wouldn't want it. I guess, I thought it was just his right to refuse and I didn't know that I should re-approach him. He couldn't make a decision about it before and in the past couple of weeks, he's cleared now and he probably could make an informed decision." Facility policies for the pneumococcal and influenza immunizations identify the need for resident/family education in order for the resident/family to provide informed consent related to the immunizations.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 371		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 49 review the facility failed to store food service equipment in a sanitary manner to prevent the transmission of food bourne illness and physical contamination to food, having the potential to affect 70 of 70 residents who ate at the facility. Findings include: During the initial kitchen observation at 1:33 p.m. on 1/23/12, the Hobart meat slicer was stored on the counter top covered and was considered clean. The meat slicer had an accumulate of food residue on the blade rotator and sharpener component, which was an area in which food came in contact with when slicing. The stove hood vents, situated above the grill and open cooking range, were soiled with a brown/black substance and thick layer of dust build up. An Edmund industrialized sized can opener was attached to the end of the steam table area. The can opener blade was dull and had metal chard's behind the blade. Dietary manger (DM) confirmed these observations. During interview at 1:42 p.m. on 1/23/12, Cook-A confirmed the meat slicer was last used yesterday for slicing roast beef. Cook-A demonstrated how to take apart the meat slicer for cleaning. Cook-A stated she was unaware the sharpener component, the area in which had an accumulate of food residue, was removable for cleaning and sanitizing. During interview at 1:44 p.m. on 1/23/12, DM stated staff were to take apart the meat slicer	F 371		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 50 after every use, clean and sanitize the machine and send the detachable components through the dishwasher, including the sharpener component. DM reported she was unsure the last time the blade was changed on the industrial sized can opener because it was rarely used but confirmed staff used it on occasion. During a follow-up observation at 7:32 a.m. on 1/25/12, Cook-B was asked to disassemble the meat slicer, which was covered and considered clean. Cook-B detached the sharpener competent. The blade rotator situated under the sharpener component had a build up of food residue. Cook-B confirmed the observation and without cleaning or sanitizing the machine, reassembled the machine and covered it for the next use. Cook-B reported the meat slicer was used one to two times a week to slice meats. During a follow-up observation at 1:35 p.m. on 1/26/12, DM was asked to disassemble the meat slicer, which was covered and considered clean. DM detached the sharpener competent. The blade rotator situated under the sharpener component had a build up of food residue. DM stated she asked staff to clean and sanitize the machine after the first observation on 1/23/12 but did not follow-up to monitor if the task was done appropriately. DM verified the stove hood vents had not been cleaned and still contained brown/black substance and thick layer of dust build up. DM stated she did not have the vents cleaned because "they were just cleaned on the fourth." DM further stated if she observed something that was soiled or dirty it would be cleaned. DM stated the stove hood vents should have been cleaned after the initial observation	F 371		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 51 and may need to be cleaned more frequently to prevent dust build up. The Hobart meat slicer instructions for cleaning dated 2/01, identified the meat slicer had a top knife cover (sharpener component) that contained the meat slicer sharpener. The instructions indicated the meat slicer machine must be thoroughly cleaned and sanitized after each day's operation or after being idle for an extended period of time. It instructed to remove the sharpener and top knife cover. It identified the top knife cover, deflector and the sharpener housing unit (also part of the sharpener component) needed to be wiped out with no residue remaining inside the sharpener housing unit and on the blade and clean the sharpener in a sink. It instructed to rinse with fresh water and to not wash the slicer components in the dishwasher. R42 obtained ice for ice water from the large ice machine in the North Dining Room without practicing good infection control technique, potentially contaminating the ice machine. At 1:00 p.m. on 1/25/12, R42 entered the dining room to get ice for water. She took the scoop out of the bin and set it on the counter. R42 walked to the sink and dumped part of water from the pitcher. R42 went back to the ice machine with the pitcher. Holding the water pitcher inside of ice machine, R42 used the public scoop to place ice inside of her pitcher coming in contact with pitcher. R42 packed the ice down with the scoop and added more ice again coming in contact with the pitcher. R42 placed the scoop in the ice machine while she set the pitcher down on her walker. R42 then returned the scoop to the plastic	F 371		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 52 bin for ongoing use. At that time R42 verified the pitcher was hers that she had been using the pitcher "since yesterday. I get my own ice water every day. The staff is just so busy." Although there were 4 staff members in the dining room at the time of this incident, no staff intervened with the practice. Nursing Assistant (NA)-C at 1:30 p.m. on 1/25/12 stated "I saw her come in and get her ice. She's really clean. As long as they (residents) wash their hands and stuff, it hasn't been a problem. She's a really clean person. She always gets her own (ice). I've never noticed it to be a problem." When the observation was described to the Infection Control Nurse and the Director of Nursing (DON) at 12:45 p.m. on 1/26/12, the DON stated she would work on this issue as it was "not my first choice" for practice.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 428		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 53 facility failed to ensure that each resident's medication regimen was free of irregularities related to the administration of Lanoxin (digoxin, a cardiac medication) without regular monitoring of the pulse for 1 of 10 residents (R91) reviewed in the sample for unnecessary medications. Findings include: R91 did not have the irregularity of digoxin administration without the monitoring of pulse identified by the monthly pharmacist's drug review. R91 had multiple diagnoses including atrial fibrillation. R91 had a Physician's order for Lanoxin (digoxin) 0.25 mg by mouth every day. The order dated back to admission on 6/6/11. R91 was admitted with facility standing orders which included an order to hold the administration of digoxin if pulse less than 55. Review of the medication administration records (MAR's) revealed there was no pulse documented for the months of 11/11, 12/11, or 1/12. There was also no information on the MAR directing the facility staff to hold the digoxin for a pulse less than 55 or a prompt to take the pulse prior to administration. Interview with RN-C on 1/26/12 at 8:15 a.m. revealed "I don't know why we don't take her pulse anymore. I'm thinking we used to but we don't do it anymore - but I don't know why. It's fallen off for a few residents where we used to do it and now we don't anymore." Clinical Manager-B (CM-B) on 1/26/12 at 8:30 a.m. indicated she had no additional information and verified the orders were accurate and the pulse should have been taken prior to administration of the digoxin.	F 428		

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 54 Review of the monthly pharmacy reviews for medication irregularities revealed no issues identified with the administration of the digoxin for the months of 11/11, 12/11, or 1/12. When the November review was completed, the resident was in the hospital. Per the consulting pharmacist on 1/26/12 at 3:15 p.m. he verified the pulse should have been checked prior to administering the digoxin.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 55 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement and maintain an infection control program to help prevent the development and transmission of infections, failure to follow the recommendations for hand hygiene, appropriate implementation of contact precautions, and proper sanitation of cleaning equipment. This deficient practice had the potential to effect all 70 residents who resided in the facility. Findings include: Although R67 was in contact precautions, staff did not consistently utilize the contact precautions appropriately as directed by facility policy. R67 did not have a comprehensive care plan related to infection control precautions. R67 was admitted to the facility on 11/2/11. She had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11, R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 56	F 441		

causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room according to the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12.

At 9:05 a.m. on 1/25/12, R67 was served her breakfast tray. Nursing Assistant (NA)-A entered the room without donning personal protective equipment (PPE). NA-A set up R67's tray, placed it on the over-bed table, touching the table with her hands and brushing against it with her uniform. NA-A then assisted R67 to wash her hands, placed sanitizing gel in her own hands and applied the gel onto R67's hands, assisted resident to wash her hands prior to eating. NA-A placed the spoon in R67's hand. NA-A then left R67's room, utilizing sanitizing gel to her own hands. NA-A left the room to get a clothing protector and straws. NA-A again entered the room with no PPE, placed straws in R67's drinks and placed the clothing protector around R67 coming in contact with R67 and the wheelchair with her hands and uniform. NA-A left the room again, this time without washing her hands. She went to the food tray cart, which was stationed in the hallway by R67's room, to obtain jelly from a public bowl of jelly on top of the cart. NA-A returned to the room with the jelly without washing hands or donning PPE. She then finished setting up the breakfast tray for R67. NA-A did not wash hands upon leaving the room.

An interview with NA-A at 9:20 am on 1/25/12, indicated she was told "only have to gown/glove when coming body to body contact." She clarified

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 _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 57 that touching items in the environment wouldn't have been a concern. It's "only if you touch the resident." When asked specifically about touching the resident's hands to wash them and her body to place the clothing protector NA-A stated "Oh yeah you're right I should have put on gloves." NA-A was asked about when to wear a gown and she reported she didn't need to wear one. "Only when doing cares and body to body contact." At 9:35 a.m. on 1/25/12, clinical manager (CM)-A stated "Staff should gown and glove when in direct contact with the resident - although the hands I'm thinking maybe it's not an issue." Explained to CM-A that NA-A washed the residents hands and brushed up against w/c and tray table. CM-A stated "I will check with (the Infection Control Nurse) to be sure what our policy is. She should be washing her hands when she comes into the room and when she leaves the room - foam in foam out." When asked what should be done with the food cart, specifically the bowl of jelly that was potentially contaminated by the infection control breach, CM-A stated "I'm not sure what we would do with the jelly. I will check with (the infection control nurse) and let you know." At 9:50 CM-A returned and verified NA-A should have gowned and gloved if she's brushing up against the resident and wheelchair and touching the resident. When asked what was going to be done with the food cart and the jelly CM-A stated "We should throw away the jelly and wash the bowl obviously." When informed the cart and the jelly remained in the hall for use, CM-A stated "Oh, I'll go get rid of it right now and we'll talk to (NA-A). Interview with the Director of Nursing (DON) and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 58 Infection Control Nurse at 12:45 p.m. on 1/26/12 verified this incident was a breach in their infection control practice. They further indicated NA-A had been re-educated and they would re-educate other staff as well on the infection control protocols including contact precautions. The facility policy "Contact Precautions" dated 1/08 and provided by the DON as current indicated "Gloves should be worn when entering the room and while providing care for a resident." The policy further directed staff to wash their hands after glove removal and "hands should not touch potentially contaminated environmental surfaces or items." The policy indicated gowns should be worn "if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the room." The policy did not identify the term "substantial". According to the DON at 12:45 p.m. on 1/26/12, she would consider substantial to be if the staff member was going to physically come in contact with the resident or the environment. Although the policy identified "Patient Transport" there was no definition of when a resident may come out of their room or what precautions needed to be taken to do so. Hand hygiene was not completed after handling a soiled dressing, removing gloves and proceeding to apply a clean dressing during R113's observed dressing change for an open stage II coccyx pressure ulcer. During observation at 10:12 a.m. on 1/26/11, clinical manger (CM)-A provided wound care treatment for R113. CM-A washed then gloved her hands, soaked a gauze with normal saline	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 59 and cleansed R113's coccyx area, wiping around the wound and wound bed, which had a zinc ointment applied. CM-A then took off the glove on her right hand, pulled a glove out her scrub pocket, and placed the glove on her right hand. CM-A was asked if it was her practice to use gloves stored in her scrub pocket at which time, CM-A then ungloved her hands, threw them away, and went into the bathroom to change her gloves. CM-A did not complete hand hygiene after handling soiled gauze and changing her gloves. CM-A confirmed she did not perform hand hygiene after handling the soiled gauze with gloved and after changing her gloves. CM-A stated it was not her practice to complete hand hygiene after handling the soiled gauze and changing gloves when completing a dressing. The Centers for Disease Control (CDC) identifies that hygiene continues to be the primary means of preventing the transmission of infection. The CDC identified hand hygiene was required after handling soiled dressings and after removing gloves.	F 441		

FEB 2 4 2012

OAKLAWN
HEALTH CARE CENTER
The Thro Company

February 22, 2012

Ms. Marge Meeker
Minnesota Department of Health
3333 West Division Street
Suite 212
St. Cloud, Minnesota 56301-4557

RE: Project Number S5517023

Dear Ms. Meeker,

Please accept the enclosed plan of correction, in response to the standard survey completed at Oaklawn Health Care Center in Mankato, Minnesota, on January 26, 2012, as our credible allegation of compliance.

Please contact me with any questions or concerns. I can be reached at 507-388-2913.

Respectfully Submitted,

Rick Krant
Administrator

OK 3/01/12

201 Oaklawn Avenue, Mankato, MN 56001

p 507.388.2193 f 507.388.1235
www.throcompany.com

OAKLAWN
HEALTH CARE CENTER
The Thro Company

DATE: February 22, 2012

SUBJECT: Plan of Correction for the 2012 Certification and State Licensing Standard Survey completed at Oaklawn Health Care Center in Mankato, Minnesota by the Minnesota Department of Health and Public Safety on January 26, 2012.

It is the policy, and intention, of Oaklawn Health Care Center to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility's CREDIBLE ALLEGATION OF COMPLIANCE.

F 241 483.15 (a) DIGNITY AND RESPECT OF INDIVIDUALITY
21805 MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac. Bill of Rights

Oaklawn Health Care Center does promote care for all of its residents in a manner and environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality.

During the survey, one surveyor noted that Resident #56 indicated, during an interview, that she was "legally blind" and that her vision had declined within the past several months. The surveyor also documented that Resident #56 stated that "They don't give me a lot of help at meals. I have a hard time feeding myself, getting the food on the fork and getting it to my mouth."

Oaklawn Health Care Center has been monitoring the resident's gradual visual acuity decline throughout her residency. The resident was seen by her ophthalmologist on 5/17/11, 11/17/11, and 2/14/12. Although there had been a decline in the resident's visual acuity, consistent with her diagnosis, the resident did not verbalize any concerns regarding difficulty with meals until her quarterly care conference on 1/25/12. Prior to that conference, facility staff had repeatedly assessed her nutritional status and ability as evidenced by the dietary manager's assessment notes in the resident's medical record. Facility staff has not witnessed the dining behaviors the surveyor had noted.

201 Oaklawn Avenue, Mankato, MN 56001
p 507.388.2193 f 507.388.1235
www.throcompany.com

The resident's weight has been stable and her meal consumption has been consistent at 50-75% of her meals consistently. Even the surveyor's example on page 3 of the Statement of Deficiencies supports the resident's mealtime functional vision when she states, "As she attempted to get her food onto the fork, her carrots and beets were pushed off of the plate onto the table. She would pick them up, place them back onto her plate and continue to eat, attempting to push them onto her fork with her free hand." Having the ability to pick up small pieces of carrots and beets would require significant visual acuity. When the resident did bring her dining experience concerns to the attention of the Interdisciplinary Team (IDT), during her conference on 1/25/12, staff immediately intervened by trialing a black plate to enhance contrast between the plate and the resident's food. Later it was determined that the resident preferred a divided plate to enhance mealtime dexterity.

Resident #56 had a MDS Assessment completed on 1/18/12. At that time, B1000 Vision was scored at a #1 IMPAIRED – sees large print, but not regular print in newspapers/books. Additionally, a fall risk assessment was completed on the resident on 1/24/12 with her Sensory Deficit/Vision reflecting the same score as noted above. On 1/25/12 the therapeutic recreation director documented, "She continues to read the newspaper in the north wing courtyard everyday." Staff have validated that she can see the newsprint and has read the stories.

The surveyor reported that the resident stated, "They don't give me a lot of help at meals." Later in the example, the surveyor notes on page 4 of the Statement of Deficiencies that the resident stated, "I like to be independent." Additionally, the resident was noted to state, "I just really want to do things for myself as much as I can. I don't want everyone to know I can't see."

It is the facility's position that a dignified dining experience was provided Resident #56 by facilitating her independence. Once her concern was verbalized regarding the dining experience, facility staff took immediate measures to provide her with adaptive eating utensils which supported her continued independence at mealtime. A more aggressive intervention would have drawn additional attention to the resident and threatened her independence.

This plan and response to CMS-2567 regarding F 241 483.15 (a) and MN St. Statute 144.651 Subd. 5 is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

The resident identified in the example had concerns with the dining experience which were immediately addressed by the IDT. Facility staff provide adaptive eating utensils and continue to monitor her meal consumption, weight, and dining performance. The resident's sensory decline has been appropriately documented, since her admission, with timely revisions to her care plan as necessary. Social

Services periodically assess the resident for any concerns with dignity as it relates to her health status and residency.

Facility Wide Response Affecting All Residents:

1. Facility staff will be re-educated on the necessity for vigilant monitoring of any resident behavioral changes as it relates to the dining experience, or any other daily function. Staff will review the necessity to notify the nurse in charge if any resident status change is noted.
2. Dietary and nursing staff will review interventions to enhance the dining experience for those residents with visual impairments. Facility staff will discuss dignified approaches to providing assistance to residents identified, while promoting and enhancing the residents' optimal level of independence and dignity.
3. *Ongoing:* Daily compliance will be monitored by the respective nurse and dietary manager. Quarterly dining room audits as they relate to a dignified dining experience, will be conducted as a part of the facility's Continuous Quality Improvement (CQI) initiative for not less than one year. Data obtained from the audits will be reviewed, with recommendations made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed March 11, 2012.

F 242 483.15(b) SELF-DETERMINATION-RIGHT TO MAKE CHOICES
21045 MN St. Statute 4658.0620 Subp. 4 Frequency of Meals, Dining Room

Oaklawn Health Care Center does allow residents the right to choose activities, schedules, and health care consistent with interests, assessments, and plans of care. Residents are given the opportunity and do make choices about aspects of life in the facility that are significant to the resident.

During the survey, one surveyor documented that the facility failed to ensure that residents had choices related to food and snacks. Residents do have choices both at meal and snack times. Residents are routinely asked about food preferences and reminded that alternatives are always available. Formally, this information is included with every care conference. The surveyor's findings may be reflective of the facility not 'publicizing' food alternatives conspicuously enough.

Resident #46 had been assessed for food likes and dislikes prior to the survey. The resident had never shared with facility staff that she did not like pork. Although there may not have been a dietary staff present in the dining room during the entire dining experience, dietary staff do serve coffee throughout the meal time and also return to serve desert. There was a nursing staff member

present in the dining room during the entire time. At any given point in time, the resident could have requested an alternate to the entrée which was served.

Resident #56 routinely consumes 50-75% of her meals and her weight has been stable. At no time has she complained about the meals offered. The surveyor references the resident's daughters in her example on page 7 of the Statement of Deficiencies. Resident #56 does not have any daughters. The facility is concerned regarding the validity of this example.

Resident #28 was admitted in September, 2011 with a weight of 213 lbs. At the time the daughter brought her concern to the dietary manager's attention, the resident weighed 218 lbs. Currently the resident weighs 215 lbs and has not weighed more than 5 lbs over her admission weight since admission. The dietary manager had discussed snack options with the resident's daughter, and she had agreed to trying 'small portions' at mealtime and not alter her afternoon snacks at this time, since the resident did enjoy the snacks and they contributed to her quality of life.

Resident #67 had also been informed of her right to meal and snack choices. Facility staff completed a call light analysis for a 48 hour period of time on Resident #67. Staff responded to her call light 19 times, including meal times, in that 48 hour period. Additionally, the resident did have access to her call light at all times. The facility would argue that the resident did have ample opportunities to request an alternative if she did not like what was being served her.

This plan and response to CMS-2567 regarding F 242 483.15 (b) and MN St. Statute 4658.0620 Subp. 4 is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

The dietary manager will meet, on an individual basis, with all of the residents and/or resident responsible parties, identified in the example, with the exception of Resident # 67 who has discharged from the facility, to discuss meal and snack options and alternatives. Facility staff will continue to verbalize choice options while serving meals and snacks.

<u>Facility Wide Response Affecting All Residents:</u>

1. The facility will re-educate nursing and dietary staff regarding the 'nourishment carts' including the importance of offering the residents a choice when they are passing the cart.
2. The facility will re-educate nursing and dietary staff regarding the necessity of offering an alternative to residents not consuming meals and snacks.

3. Nutrition options and choices will continue to be discussed routinely, including during care conferences, with residents and resident responsible parties.
4. The facility will display entrée alternatives on the menu postings outside of the facility dining rooms. Menu's, including an entrée alternative and an 'always available' selection will be available at each resident's dining room table and to those who do not dine in the dining rooms.
5. *Ongoing:* Daily compliance will be monitored by the respective nurse and dietary manager. Quarterly dining room and room service audits as they relate to meal and snack time choices, will be conducted as a part of the facility's Continuous Quality Improvement (CQI) initiative for not less than one year. Data obtained from the audits will be reviewed, with recommendations made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed March 11, 2012.

F 272 483.20 (b)(1) COMPREHENSIVE ASSESSMENTS
2540 MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment

Oaklawn Health Care Center conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity at the time of admission, quarterly, and if the resident's condition changes. The facility does complete comprehensive assessments of resident's needs using the RAI specified by the State. The assessment does include all of the specified required information.

During the survey, one surveyor noted that Resident #113 was not comprehensively assessed for risk factors and interventions to minimize the risk for pressure ulcer development and the worsening of pressure ulcers. The surveyor reported that there was missing documentation in the resident's chart and questioned the facility's wound care approaches. This particular resident is actively dying, refusing most meals, and is more than likely in a negative protein balance. The resident has been identified as 'high risk' as it relates to the development of skin integrity impairments. Although there may have been a documentation concern noted in the surveyor's findings, the resident's wound is completely healed at the time of this writing. The outcome of this particular example would support that the facility had implemented the appropriate nursing interventions to facilitate the resolution of the noted skin integrity impairment, despite all of the unfavorable circumstances for wound healing.

Resident #93 had been evaluated by Occupational Therapy (OT) 6/20/11. The resident is a Veteran's Administration (VA) beneficiary. At the time of the resident's OT evaluation, the VA provided a gel over foam type of wheelchair

positioning/cushion device. The resident has a history of 'sacral sitting' since his admission to the facility. Resident #93 has always self-advocated and has had no limitations on making his needs and desires known to facility staff. As a result of the surveyor's documented alleged resident wheelchair positioning concerns, OT re-evaluated the resident for wheelchair positioning. Following the resident's 1/30/12 OT re-evaluation, it was recommended that the facility try a 20"W x 18"D wheelchair Hemi ht with full armrests Incrediback to accommodate his kyphosis and taller torso. In addition, it was recommended that the facility pursue a low profile pressure relief cushion to decrease pressure areas. Since the facility was unable to get a timely authorization from the VA to purchase the adaptive wheelchair positioning equipment, the facility purchased the adaptive equipment and implemented its use per OT recommendation. As of 2/15/12, the resident acknowledged his wheelchair comfort, however his 'sacral sitting' continues and his positioning has remained unchanged since the observation of the surveyor. The resident was provided education on the risks associated with his continued wheelchair positioning. When questioned, the resident made it clear that he had no concerns and how he sat was his 'business'.

On 2/17/12 the director of nursing followed-up with Resident #93 regarding his continued sacral sitting. Resident #93 stated, "I sit this way because I want to. No matter what chair I have I will sit this way; I am comfortable."

Facility Wide Response Affecting All Residents:

1. The facility has adopted a revised policy for "Prevention of Pressure Ulcers" and "Pressure Ulcer Treatment." Facility nursing staff will be educated regarding the changes to facility policy, procedure, and protocols.
2. Pressure ulcer prevention strategies and wound care management education will be provided to the licensed nursing staff by the facility's wound care nurse consultant.
3. The facility's nurse managers will conduct weekly wound rounds of the residents assigned on their respective caseloads. Outcome reports will be made to the director of nursing for collaboration of care, monitoring, and follow-through.
4. 'Tissue Tolerance Observations' will be reviewed by the respective nurse manager timely. The respective nurse manager will implement strategies to ensure timely completion of the required assessment.
5. Wheelchair positioning assessment criteria has been added to the "Interdisciplinary Care Conference and Quarterly Review Checklist Documentation Sheet" which will be completed to evaluate resident positioning, comfort, and potential concern regarding wheelchair positioning. Referral will be made to OT if there are any concerns assessed by the IDT or voiced by the resident.
6. *Ongoing:* A random sample of residents identified as having integumentary 'concerns' will be selected for audit on a quarterly basis. The said audit will include information regarding timely

completion of assessments, accurate documentation of weekly 'wound rounds', weekly progress note documentation, and the timely completion of Tissue Tolerance Observations. The data obtained from these audits will be presented as part of the facility's Continuous Quality Improvement (CQI) initiative for not less than one year. Data obtained from the audits will be reviewed and compared to state, regional, and federal QI/QM comparisons, with recommendations made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed March 11, 2012.

F 279 COMPREHENSIVE CARE PLANS
2555 MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development

Oaklawn Health Care Center uses the results of a comprehensive assessment of each resident to develop, review and revise the resident's comprehensive plan of care. The comprehensive care plans include measurable goals in order to meet each resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

During the survey, one surveyor noted that Resident #67's comprehensive plan of care included an entry addressing the resident's Clostridium difficile (C diff.) infection, which the surveyor identified as not identifying the contact precautions to be used with the resident, if the resident could leave the room, at what point the precautions would be lifted, and what psychosocial things were going to be done while the resident was required to stay in her room. The facility had ongoing documentation on the resident's status with ever-changing interventions specifically individualized to the resident's condition. The facility does have specific contact precaution policies which address all of the areas that the surveyor noted in her example.

This plan and response to CMS-2567 regarding F 279 483.20(d), 483(k)(1) and MN Rule 4658.0405 Subp. 1 is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

The resident's care plan was updated to include the contact precautions, if the resident could leave her room and if so what needed to occur before leaving the room, when the precautions could be lifted in accordance with the facilty's Clostridium Difficile Policy. The psychosocial interventions were also updated to include in the room activities while she was required to be in her room. The nursing assistant's 'Care Sheets' were also updated to include the specific contact

precautions required. All of this was completed prior to the completion of the survey.

Facility Wide Response Affecting All Residents:

1. Facility licensed staff will be re-educated on the importance of developing individualized care plans based upon assessed resident needs during the comprehensive assessment process.
2. *Ongoing:* A random sample of resident charts will be audited by the director of nursing to ensure timely, correct care plan entries have been made on the respective residents involved in the audit. The data obtained from these audits will be presented as part of the facility's Continuous Quality Improvement (CQI) initiative for not less than one year. Upon recommendations made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed March 11, 2012.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE IN PLANNING CARE-REVISE CP
2560 MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents

Oaklawn Health Care Center recognizes and ensures residents' right to participate in planning care and treatment or changes in care and treatment. Upon completion of a comprehensive assessment, a comprehensive care plan is established. The comprehensive care plan is developed, based upon the resident's needs, by the interdisciplinary team, the resident, and the resident's family or legal representative. The comprehensive care plan is periodically reviewed and revised by the aforementioned individuals after each assessment.

During the survey, one surveyor reported that Resident #56's care plan was not revised as appropriate related to fall risk and unavoidable sensory decline in vision.

Resident #56 does not have a history of falls. The facility reviewed data for the past year and has noted that the resident's fall on 1/20/12 was the only fall on record in the past year. The fall was not associated with the resident's visual decline. The resident's visual status had not triggered a care plan entry previous to the fall, nor did it following the fall. The resident's care plan does encourage ambulation with one assist and a walker. However, in the spirit of cooperation, the facility discussed modifications to the resident's care plan with her. Subsequently, a night light and keeping her room as clutter-free as possible was added to the resident's plan of care.

The surveyor stated in her example that there were no immediate interventions taken on the part of the nurse assigned at the time of Resident #56's fall. There were immediate interventions taken by the nurse and these were documented in the nursing notes. The interventions involved moving the resident's walker and wheelchair in the resident's room to discourage attempts at independent transferring during the night and to remind her to call for assistance. The facility's Fall Risk Management Policy identifies the role of the Charge Nurse as responsible for completing the incident report if there is an incident involving a resident. In addition, it indicates to 'Initiate immediate necessary interventions to prevent further falls." The policy further states that it is the Nurse Manager's responsibility to document interventions identified on the facility's Fall Risk Assessment once it has been completed. Upon completion of the Fall Risk Assessment and subsequent IDT review, modifications to the resident's plan of care were made, which amounted to adding a bed exit sensory pad to the resident's bed. The staff involved were following the facility's policies and procedures throughout the cited example.

On page 24 of the Statement of Deficiencies, the surveyor referenced Resident #56 as having an 'acute UTI which was not identified at the time of the resident's fall.' Resident #56 did not have an acute UTI at the time of the fall. Perhaps the surveyor noted that this particular resident was on a physician-prescribed (including the appropriate risk vs. benefit analysis) prophylactic antibiotic which the surveyor failed to identify as prophylactic and assumed the resident had an acute infection. Regardless, this section of the surveyor's example is erroneous.

Resident #56 was noted to be reading the newspaper on 1/26112, 1/27/12, 2/3/12, 2/6/12, & 2/10/12 at which times she could see the regular newspaper print as confirmed by facility staff by her valid discussion of the stories read. It is the facility's position that the resident's current plan of care appropriately identifies the resident's needs and are appropriate interventions for her individualized assessed needs. As the resident's vision declines, appropriate revisions to her plan of care will be made.

This plan and response to CMS-2567 regarding F 280 483.20(d)(3), 483.10(k)(2) and MN Rule 4658.0405 Subp. 2 is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

Facility Wide Response Affecting All Residents:

1. Nursing staff will review the facility's Fall Risk Management Program with re-education offered to appropriate staff. The 'Post Fall Huddle' information will be emphasized, particularly as it relates to determining immediate interventions that can be implemented with the resident following a fall to reduce the risk of further falls.

2. The 'Standard Fall Precautions' and the 'High Risk Fall Precautions' will be added to the facilities electronic medical record prompting reinforcement to facility nursing assistants of the importance of all staff being aware of residents' risk for falls.
3. All residents identified by a score greater than 'low risk for falls' on their required fall assessment will have their assessed visual limitations addressed in their respective plans of care.
4. *Ongoing:* Quarterly audits of randomly selected incident reports involving resident falls will be conducted to ensure appropriate immediate interventions are identified and incorporated into the residents' plans of care. Documentation review for accuracy and consistency will be conducted as part of the facility's CQI initiative for not less than one year. Data obtained from the CQI process will be reviewed, with recommendations for intervention made, during the quarterly CQI meetings.
5. *Ongoing:* A random sample of residents assessed to have visual impairments, will be audited to ensure fall risk interventions are identified and incorporated into the respective residents' plans of care. The data obtained from these audits will be presented as part of the facility's Continuous Quality Improvement (CQI) initiative for not less than one year. Upon recommendations made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed March 11, 2012.

F 282 483.20(k)(3)(ii) SERVICES BE PROVIDED BY QUALIFIED PERSONS PER CARE PLAN
2565 MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use

The services provided or arranged for by Oaklawn Health Care Center are provided for by qualified persons in accordance with each resident's written plan of care.

The surveyor noted that Resident #91did not receive the pressure ulcer education as directed by her current plan of care. Appendix A clearly demonstrates that the nurse manager provided the resident education on the importance of hourly off-loading. Wheelchair repositioning as it relates to tilting her wheelchair back and rest in bed or recliner between daily activities was also addressed and is supported in the documentation in Appendix A. Pressure-relieving devices and nutritional interventions were also addressed. Additionally, the resident's daughter, who is the resident's responsible party, was made aware of the aforementioned information as well. On 10/13/11 there is a corroborating note from one of the facility's night nurses which addresses the nurse's encouragement to the resident to reposition and utilize pressure relief cushion. The resident has a long history of refusing pressure-relieving interventions, even after the resident has been

provided with information regarding pressure ulcer management and prevention. This information is clearly documented throughout the resident's medical record.

The surveyor even noted on page 27 of the Statement of Deficiencies did not lay down on 1/25/12 on the dayshift and when she was approached the Resident #91 stated, "I'm busy." Additionally, the resident stated on 1/26/12 that "there's three nurses on me all the time" regarding interventions to prevent pressure-related integument alterations.

After a comprehensive review of the requirement at F 282 483.20(k)(3)(ii) Services provided by qualified persons in accordance with each resident's written plan of care and in MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use, it is the facility's belief that it was in full compliance with the requirement at the time of the survey.

This plan and response to CMS-2567 regarding F 282 483.20(k)(3)(ii) Services provided by qualified persons in accordance with each resident's written plan of care and in MN Rule 4658.0405 Subp. 3 is written in the spirit of cooperation and solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

Resident #91 has been addressed again on the importance of her repositioning and compliance with pressure-relieving interventions. The resident continues to refuse. The facility is respectful of the resident's right to refuse treatment as clearly defined under F 155 483.10(b)(4) and MN St. Statute 144.651 Subd. 12.

<u>Facility Wide Response Affecting All Residents:</u>

1. The facility will continue to develop individualized care plan interventions for facility residents based upon the comprehensive assessment. Facility staff will continue document education provided to residents and resident responsible parties as it relates to identified interventions and resident education. Resident non-compliance and/or refusals of care will be documented with staff re-approaching at different times. Facility staff will continue to acknowledge the resident's right to refuse care and treatment as clearly outlined in the Resident's Bill of Rights.
2. *Ongoing:* Quarterly audits of a random sample of residents will be conducted to ensure that resident care plan interventions, including education on individualized, resident-specific care plan interventions, have been identified thoroughly and addressed in the resident's plan of care. Resident refusals of care will be analyzed to ensure that appropriate resident and/or resident responsible party education has occurred. These audits will be conducted as part of the facility's CQI

initiative for not less than one year. Data obtained from the CQI process will be reviewed, with recommendations for intervention made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed March 11, 2012.

F 309 483.25 PROVIDE CARRE/SERVICES FOR HIGHEST WELL BEING
2830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General

Oaklawn Health Care Center ensures that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

During the survey, one surveyor stated that one resident did not receive appropriate wheelchair positioning. This citation is cross-referenced at F 272 under wheelchair positioning. Please refer to F 272 for the facility's response.

During the survey, this same surveyor stated that Resident #56 had a fall which was not reviewed to ensure adequate safety interventions for 4 days. This is a false statement as discussed in the response at F 280. This citation is cross-referenced at F 280 and the reader is referred to that section for the facility's response. It should be noted again, that the surveyor's statement that Resident #56 was being treated for a UTI at the time of her fall was presumptive and erroneous. Resident #56 receives a prophylactic antibiotic based upon an individualized risk vs. benefit analysis concluded by her attending physician. The resident did not have an infection as the surveyor notes.

F 311 483.25(a)(2) TREATMENT/SERVICES TO MPROVE/MAINTAIN ADLS
2915 MN Rule 4658.0525 Subp 6 A Rehab – ADLs

The residents of Oaklawn Health Care Center are given appropriate treatment and services to maintain or improve his or her abilities.

This citation is cross-referenced at F 241 where there is an in-depth discussion of this particular surveyor's finding with one resident. It should be noted that the surveyor reports that Resident #56 stated that she never brought her mealtime concerns to the attention of therapy staff in an effort to explore adaptive eating devices and/or any other facility staff. In fact, later in the example, Resident #56 shares with the surveyor how she wants to be independent and how she doesn't want 'everyone to know that I can't see." It is quite plausible that the resident's

concerns were made known to facility staff simultaneous to when she made her concerns known to the surveyor. Interestingly enough, the sequence of events in this example would support that possibility. According to the example cited by the surveyor, Resident #56 brought her concerns to the attention of the surveyor on 1/24/12. During the resident's care conference on 1/25/12, the resident brought her concerns to the attention of the IDT. The IDT took immediate remedial measures once the resident's concern was made known. Facility staff would not have known of the resident's conversation with the surveyor on 1/24/12 until at the time of the Health Department's exit conference on 1/26/12. Prior to her making her concerns known during the week of 1/23/12, the resident did not exhibit any mealtime challenges. Refer to F 241 for a full discussion of this finding and identified remedial measures.

F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES
2900 MN Rule 4658.0525 Subp. 3 Rehab – Pressure Ulcers

Oaklawn Health Care Center uses information obtained from the comprehensive assessment to ensure that resident's who enter Oaklawn without pressure ulcers do not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. Residents having pressure ulcers receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This citation is cross-referenced at F 272 & F 282. Please refer to F 272 & F 282 for the facility's response.

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVSION/DEVICES

Oaklawn Health Care Center does ensure that the resident environment remains as free of accident hazards as is possible. Each resident does receive adequate supervision and assistance devices to prevent accidents.

The example used in citation F 323 is cross-referenced at F 280. Please refer to F 280 for the facility's response.

F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
21535 MN Rule 4658.1315 Subp. 1 ABCD Unnecessary Drug Usage; General

Each resident, residing at Oaklawn Health Care Center, has a drug regimen that is free from unnecessary drugs. Residents are free from excessive dosing, excessive

duration of medications, and do have adequate monitoring and indications for the medications they receive. Residents' drug regimens are routinely monitored for adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

During the survey, one surveyor noted that Resident # 91's pulse was not taken prior to the administration of Lanoxin as ordered by her physician. The resident's nurse manager inadvertently discontinued pulse checks at an earlier date. Resident #91 was the only resident affected by this action.

Since the time of the survey, pulse checks prior to administering Resident #91's Lanoxin have been added back to her plan of care.

This plan and response to CMS-2567 regarding F 329 483.25(l) and MN Rule 4658.1315 Subp. 1 ABCD is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

Facility Wide Response Affecting All Residents:

1. Apical pulse checks prior to the administration of Lanoxin (Digoxin) has been entered as an automatic entry to the electronic medication administration record. The nurse is directed to complete this assessment per facility standing orders and to hold the medication and contact the residents' health care provider in the event that the assessed pulse is less than 55 bpm, unless otherwise ordered.
2. *Ongoing:* Quarterly audits of residents' medication regimens will be conducted on a random sample of residents receiving Lanoxin (Digoxin). Nurses will be audited to ensure that they are completing apical pulse assessments prior to the administration of the aforementioned cardiac medications. These audits will be conducted as a part of the facility's Continuous Quality Improvement (CQI) initiative for not less than one year. Discrepancies will be brought to the attention of the attending physician and/or the director of nursing immediately. Audit results will be further reviewed and discussed, with recommendations made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed March 11, 2012.

F 334 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS

Oaklawn Health Care Center has extensive policies and procedures for influenza and pneumococcal immunization which address all of the requirements at F 334.

Specifically, the facility's Pneumococcal Disease-Prevention Protocol and Influenza-Like Illness Prevention Protocol address providing information and education to residents and/or resident representatives on the benefits and risks associated with the said vaccines. The facility's Influenza-Like Illness Prevention Protocol identifies the following under procedure: 3. Prior to vaccination administration, the resident/family will receive education regarding benefits and possible side effects of the influenza vaccine. The education will include: a. Resident/family given a copy, have read or had explained the information contained in the appropriate vaccine information materials (VIS: current year) about the disease & vaccine(s); b. Resident/family have been given opportunity to ask questions that have been answered to their satisfaction, and they understand the benefits and risks of the vaccine(s); and c. The information will be provided in the resident/family's language of choice. The facility's Pneumococcal Disease-Prevention Protocol identifies the following under procedure: 3. If the resident has not received Pneumococcal vaccination or immunization status is unknown, the resident will receive education regarding benefits and possible side effects of Pneumococcal vaccination. In all instances, the facility respects the resident's and/or resident's representative's right to refuse immunization once the benefits and risks associated with the various vaccine(s) are explained. The resident's physician is informed of resident's vaccination status.

- During the survey, one surveyor noted that Residents #115 was admitted to the facility on 1/6/12 with diagnoses that included delirium. The surveyor documented that the resident's granddaughter assisted the resident with the admission process. The resident was actually assisted by his son, who was acting on his father's behalf as representative, with the admission process. The surveyor erroneously cited the resident's granddaughter in her example. The facility's Resident Vaccine Administration Consent Form was reviewed with the resident and the resident's son. The resident and the resident's son did receive information regarding the benefits and possible risks associated with both the Influenza and Pneumococcal Vaccines. This education included the Vaccine Information Statements published by the Centers for Disease Control and Prevention (CDC) (Appendix B). The resident's son attested to having been educated on the benefits and risks of the vaccines by signing the consent form stating, "I have been given a copy and have read or have/had explained to me the information contained in the appropriate vaccine information materials (fact sheets) about the disease and vaccine(s) indicated below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the indicated vaccine(s)…." The resident's responsible party then declined the vaccinations. Facility staff were made aware that the resident's responsible party made the decision on behalf of his father in awareness of his father's repeatedly declining the vaccinations historically, and his father's not wanting the vaccine.

After a comprehensive review of the requirement at F 334, 483.25 (n) influenza and pneumococcal immunizations, it is the facility's belief that it was in full compliance with the requirement at the time of the survey. The requirement states

at 483.25(n)(1)(i) that "Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization." The resident's representative did receive that information. The requirement goes on to state at 483.25(n)(1)(iii), "The resident or the resident's legal representative has the opportunity to refuse immunization;." The facility observed the resident's representative's right to refuse the immunization on his father's behalf. Similar requirements address pneumococcal immunizations at 483.25(n)(2)(i) which states, "Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization." Again, the facility did provide that information as exhibited in Appendix B. This requirement also goes on to state at 483.25(n)(2)(iii) that "The resident or the resident's legal representative has the opportunity to refuse immunization;." Furthermore, the wishes of the resident were known to the resident's representative and were shared with facility staff. The regulation at F 334 does not require the facility to re-approach the resident if an informed decision has been made by the resident's representative, when the resident is unable to decide for him or herself, to decline the aforementioned vaccines, when that decision has been made based upon the resident's wishes.

This plan and response to CMS-2567 regarding F 334 483.25(n) is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

Facility Wide Response Affecting All Residents:

1. The facility will continue to exercise its adherence to its policies and procedures which address both influenza and pneumococcal vaccination protocols including educating residents and resident representatives on the benefits and risks of both influenza and pneumococcal vaccines. All correspondence will continue to be clearly documented in the resident's medical record.
2. When residents and/or resident representatives decline recommended vaccinations, the IDT will review the benefits and risks of the declined vaccination and offer the resident/resident representative the opportunity again at the time the IDT deems appropriate, or at the time of the resident's scheduled care conference, presuming that the conference falls within the recommended vaccination timeframe.
3. *Ongoing:* Quarterly audits, during recommended timeframes for vaccinations, of residents who have refused recommended vaccinations will be conducted for adherence to the facility's policies addressing influenza and pneumococcal immunizations. These audits will be conducted by the facility's registered nurse who is responsible for the infection control procedures of the facility. These audits will be

conducted as part of the facility's CQI initiative for not less than one year. Data obtained from the CQI process will be reviewed, with recommendations for intervention made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed March 11, 2012.

F 371 483.35(i) FOOD PROCEDURE, STORE/PREPARE/SERVE – SANITARY
21015 MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary Conditions

Oaklawn Health Care Center procures food from sources approved or considered satisfactory by Federal, State and local authorities. Oaklawn stores, prepares, distributes and serves food under sanitary conditions.

During the survey, one surveyor noted that the Hobart meat slicer was stored on the counter top covered. The surveyor noted that there was food residue on the blade rotator and sharpener component. The surveyor also noted that the stove hood vents had a brown/black substance and a layer of dust. Also noted was the Edlund industrialized sized can opener as having a blade that was dull and had metal shards behind the blade.

These findings may have resulted from staff not following the meat slicer's manufacturer's recommended cleaning procedure. The stove hood vents had been cleaned on 1/4/12, but may have required more frequent cleaning. The Dietary Manager noted that the can opener was used infrequently which may have attributed to staff not recommending the blade's replacement.

Resident #42 did not appear on the Stage 2 Sample Resident List provided to the facility by the survey team. Based upon the description, facility staff believes they know who the surveyor was referencing in the example. If the facility staff's assumption is correct, this resident prefers to be as independent as she possibly can be. Facility staff did not recognize the infection control concerns and opted to facilitate her independence by allowing her to get her own ice from the ice machine.

This plan and response to CMS-2567 regarding F 371 483.35(i) and MN Rule 4658.0610 Subp. 7 is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

Facility Wide Response Affecting All Residents:

1. The facility will discontinue its operation of the Hobart meat slicer and purchase all pre-sliced meat.
2. The dietary manager, or her designee, will inspect the stove hood on a weekly basis to ensure that there is no build-up of residue or dust. The dietary manger will coordinate the cleaning of the stove's hood as frequently as the aforementioned inspections dictate.
3. The blade on the Edlund can opener will be replaced.
4. Facility ice machines have been replaced with motion activated single-serve ice machines which eliminate any infection control risk.
5. *Ongoing:* Quarterly audits by facility staff and periodic audits by the contracted dietician of kitchen sanitation will be conducted to ensure that there are no ongoing sanitation concerns. These audits will be conducted as part of the facility's CQI initiative for not less than one year. Data obtained from the CQI process will be reviewed, with recommendations for intervention made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed March 11, 2012.

F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON
21530 MN Rule 4658.1310 A.B.C Drug Regimen Review

The drug regimen of each resident at Oaklawn Health Care Center is reviewed at least once a month by a licensed pharmacist. The pharmacist does report any irregularities to the attending physician, and the director of nursing, and these reports are acted upon.

The example used in citation F 428 is cross-referenced at F 329. Please refer to F 329 for the facility's response.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS
21375 MN Rule 4658.0800 Subp. 1 Infection Control Program

Oaklawn Health Care Center has established and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

The examples used at F 441 can be attributed to the facility's staff anxiety with having a health department surveyor analyze their performance. Each employee cited in the examples at F 441 commented on how uneasy they felt with the surveyor 'scrutinizing' their performance.

This plan and response to CMS-2567 regarding F 441 483.65 and MN Rule 4658.0800 Subp. 1 is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

The Nursing Assistant in the example dated 1/25/12 was provided corrective counseling in the form of re-education on 1/25/12. The Nursing Assistant then demonstrated to the Occupational Health and Learning Director (OHLD) that after reading the provided materials she was able to demonstrate appropriate management of the infection control process in accordance with the facility policy and procedure. The facility recognizes that the Nursing Assistant was not following proper protocol regarding management of this resident, however, the facility also recognizes that she was extremely nervous and intimidated by the survey process. In addition, immediately after being notified of the infection control concerns involving the jelly, the jelly was destroyed, the food cart was disinfected under direction of the OHLD with a bleach product to remove any risk to any other resident. The RN involved in the dressing change has received re-education as it relates to the concerns noted in the example. In addition, this RN has reviewed the facility's policy addressing dressing changes.

Facility Wide Response Affecting All Residents:

1. Mandatory staff re-education on the management of infections, particularly isolation precautions and management of Clostridium Difficile will be conducted.
2. Licensed nurses will receive mandatory re-education on dressing change policies and technique.
3. The facility will continue to provide, at least annually, education on Clostridium Difficile via The Company's approved e-learning system.
4. In the event of another case of Clostridium Difficile, 'just in time' education will be provided to all staff following the facility's approved policy and procedure addressing Clostridium Difficile infections.
5. *Ongoing:* Quarterly audits of individuals on Contact Precautions will be conducted to ensure that facility infection control policies and procedures are being adhered to. These audits will be conducted as part of the facility's CQI initiative for not less than one year. Data obtained from the CQI process will be reviewed, with recommendations for intervention made, during the quarterly CQI meetings.
6. *Ongoing:* Quarterly audits of resident dressing changes will be conducted to ensure that facility infection control and wound care policies and procedures are being adhered to. These audits will be conducted as part of the facility's CQI initiative for not less than one year. Data obtained from the CQI process will be reviewed, with

recommendations for intervention made, during the quarterly CQI meetings.

Respectfully Submitted,

Rick Krant
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5517020
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on January 31, 2012. At the time of this survey, Oaklawn Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 ST. Paul, MN 55101-5145	K 000	Please see attached Plan of correction. POC ok TS 2-27-12 RECEIVED FEB 27 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 03.07.12
EXIT: 01.26.12

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

Administrator 2/22/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Pat.Sheehan@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Oaklawn Health Care Center was constructed as follows: The original building was constructed in 1964, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II (000) construction; The 1995 building Addition is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detectors in all resident rooms which are inspected and tested monthly. The facility has a capacity of 77 beds and had a census of 69 at time of the survey. Because the original building and the one addition met the construction type allowed for existing buildings, the facility was surveyed as one	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 building and one (1) Form CMS-2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code (1999 edition) and NFPA 72 National Fire Alarm Code (1999 edition). The system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70 (99) and NFPA 72 (99) and NFPA 101 Life Safety Code (2000 edition), Chapter 9, Section 9.6.1.4. This STANDARD is not met as evidenced by: Based upon observation and interview, the facility failed to maintain the building fire alarm system in	K 052	2-22-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 3 accordance with NFPA 72 (1999 edition) Sections 2-3.5.1, 2-3.6.6.2, and 7-3.2. FINDINGS INCLUDE: On 1/31/12 between 9:30 AM and 1:00 PM, the following deficiencies were confirmed: A). During a review of available documentation provided by facility staff, it was confirmed that facility staff failed to test the Digital Alarm Communicator Transmitter (DACT) during the months of March, May, August, September, October, November and December of 2012. This deficient practice was not in accordance with CMS policy, as provided for at NFPA 72 (99) Chapter 7, Section 7-3.2. B). Smoke detectors in the following areas were located within 3-feet of HVAC return air openings and/or supply air diffusers, and were not in conformance with the requirements at NFPA 72 (1999) Chapter 2, Section 2-3.6.6.2: 1). Clean Linen Storage Room C-445; 2). Corridor near South Nurse's Station. In a fire emergency, this deficient practice could adversely affect the safety of 77 of 77 residents, staff and visitors.	K 052		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water	K 056		2-22-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 4 supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - There is an automatic sprinkler system, installed in accordance with NFPA 13 (1999), Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25 (1998), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with water flow and tamper switches which are connected to the fire alarm system, in accordance with NFPA 101 (2000), Chapter 19, Section 19.3.5. and Chapter 9, Section 9.7. FINDINGS INCLUDE: On 1/31/12 between 9:30 AM and 1:00 PM, observation revealed the Mop Closet located in the Main Dietary area was not equipped with an automatic fire sprinkler. This finding was confirmed with facility staff at the time of discovery.	K 056		

OAKLAWN
HEALTH CARE CENTER
The Thro Company

DATE: February 22, 2012

SUBJECT: Plan of Correction for the Life Safety Code Survey completed at Oaklawn Health Care Center in Mankato, Minnesota on January 31, 2012 by the Minnesota State Fire Marshal's Office.

It is the policy, and intention, of Oaklawn Health Care Center to be in compliance with all regulations and requirements of both the Medicaid and Medicare Programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101(2000).

K 052 NFPA 101 LIFE SAFETY CODE STANDARD

Oaklawn Health Care Center does have a fire alarm system required for life safety which is tested and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

On 1/31/12, during the Life Safety Code Survey, the following concerns were noted:

A). The facility's Digital Alarm Communicator Transmitter (DACT) was not tested during several months in the past year. This occurred during the simulated fire drills at the facility. During simulated fire drills, the fire alarm was not sounded to avoid interrupting residents' sleeping. However, following those simulations, and during normal waking hours, there was no activation of the fire alarm system which would have allowed testing of the DACT.

Plan of Correction:

1. Facility staff responsible for conducting quarterly fire drills has reviewed and have been re-educated on the requirement addressing fire drills in the 101 Life Safety Code Standard and facility policy and procedure.
2. The facility's Occupational Health and Learning Director (OHLD) will be responsible for conducting quarterly fire drills on each shift at unexpected times, and completing all required documentation. Following simulated fire drills, the OHLD, or her designee, will be responsible for initiating the fire alarm system with subsequent validation from the fire alarm monitoring system for verification that the DACT is functional. The facility's safety committee will monitor fire drills both scheduled and completed at the facility to ensure that the requirement is met on an ongoing basis.

Timeline for Correction: Corrected. 2-22-12

201 Oaklawn Avenue, Mankato, MN 56001

p 507.388.2193 f 507.388.1235
www.throcompany.com

B). Two smoke detectors were noted to be within 3 feet of HVAC return air openings and/or supply air diffusers. The smoke detectors were located in the clean linen storage room C-445 and in the corridor near the south nurse's station.

Plan of Correction:

1. The cited smoke detectors have been relocated and are now conform to the requirements at NFPA 72 (1999) Chapter 2, Section 2-3.6.6.2.

Timeline for Correction: Corrected.

K 056 NFPA 101 LIFE SAFETY CODE STANDARD

Oaklawn Health Care Center does have an automatic sprinkler system which provides complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

On 1/31/12, during the Life Safety Code Survey, the following concerns were noted: The mop closet located in the main dietary area was not equipped with an automatic fire sprinkler.

Plan of Correction:

1. An automatic fire sprinkler has been added to the cited dietary mop closet.

Timeline for Correction: Corrected. 2-22-12

Respectfully Submitted,

Rick Krant
Administrator

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4822

February 9, 2012

Mr. Rick Krant, Administrator
Oaklawn Health Care Center
201 Oaklawn Avenue
Mankato, Minnesota 56001

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5517023

Dear Mr. Krant:

The above facility was surveyed on January 23, 2012 through January 29, 2012 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division Street, Suite 212, St. Cloud, Minnesota 56301-4557. 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 me.

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

Please feel free to call me with any questions.

Sincerely,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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, January 23, 24, 25,and 26, 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring,	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Licensing and Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 2 comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess risk and interventions to minimize the risk for pressure ulcer development and worsening of pressure ulcers for 1 of 3 residents (R113) reviewed for pressure ulcers and related to wheelchair positioning needs for 1 of 3 residents (R93) reviewed in the sample for positioning. Findings include: R113 was admitted on 11/25/11 with a stage I pressure ulcer on his coccyx, which developed into two stage II pressure ulcers 12/18/11 and 12/20/11.	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 3 R113 had diagnoses that included urinary retention, fatigue, severely under weight, advanced dementia with depression and anxiety, and a history of infection. The admission minimum data set (MDS) dated 12/2/11, identified R113 was cognitively intact, no behavioral concerns, and required extensive assistance of one staff for repositioning. The MDS indicated R113 was at high risk for pressure ulcer development and did not have one or more unhealed pressure ulcers at a stage I or higher. The MDS revealed skin and ulcer treatments included a pressure reducing device for his chair and bed, a turning and repositioning program, and ointments/medication application to his body (not his feet). The admission initial nursing data form, dated 11/25/11, identified R113 had a reddened coccyx and identified that a tissue tolerance test was to be completed. R113's tissue tolerance observation for the lying position, dated 11/25/11, identified redness on his coccyx after lying for two hours. The observation form then instructed staff to re-observe after one and a half hours. The observation form asked after one hour was the redness noted over the boney prominences which the facility identified as "Yes, the area remained red, initiate wound care protocols stage I and redo the observation at 1 hour." R113's tissue tolerance for sitting observation dated 11/25/12 read "Unable to assess - resident in lying position through-out shift." The facility did not initiate wound care protocols for a stage I pressure ulcer to monitor the area and did not assess R113 for tissue tolerance while sitting to determine appropriate	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 4 interventions for repositioning needs. A tissue tolerance skin risk factor evaluation form, dated 12/1/11, noted R113 was at mild risk for skin breakdown. It identified he had a bio foam mattress and pressure redistribution cushion in his wheelchair. It noted he "has a reddened coccyx which was present upon admit" and to apply barrier cream to this area twice daily. On 12/18/11, a weekly wound documentation form was initiated for a stage II pressure ulcer on R113's coccyx. The form indicated R113 had a stage II pressure ulcer on his coccyx measuring 1.5 cm by 1.5 cm by 0.2 cm, with no draining or odor. The treatment included an Allevyn foam dressing and Tena with Zinc. On 12/23/11 the wound was noted to be stable, and was reassessed as a stage II pressure ulcer measuring 0.2 cm by 0.1 cm by 0.1 cm, with the same treatment. On 12/30/11 the wound was noted to be improving, and was reassessed as a stage II pressure are measuring 0.4 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/8/12 the wound was noted as stable and was reassessed as a stage II pressure are measuring 0.6 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/17/12 the area was assessed by the wound care practitioner. On 12/20/11 a weekly wound documentation form was initiated for a stage II pressure ulcer identified on the diagram as located on the lower area of the buttock and noted as a "lower open area." The form indicated R113 had a stage II pressure ulcer on his lower buttock measuring 1.8 cm by 1.2 cm by 0.1 cm, with no draining or odor. The treatment included an Duoderm dressing. On 12/25/11 the wound was reassessed as a stage II pressure ulcer	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 5 measuring 0.2 cm by 1.5 cm with no depth with 100% granulation. At this time an Allevyn foam dressing and Tena with Zinc treatment was applied and the area was noted as improved. On 1/24/12 the wound was reassessed as a stage II pressure area measuring 0.3 cm by 0.2 cm with no depth, the area was noted as dry, the treatment was changed to Mepilex Boarder and was identified as improved. On 1/17/12 the area was assessed by the wound care practitioner. No further documentation was provided to indicate that the area was monitored or assessed from 12/25/11 to 1/17/12. The physician orders and progress notes form dated 1/17/12 identified a wound care consult was completed. The note indicted R113 had stage II skin breakdown on his sacrocoxygeal area for approximately two weeks. The note identified R113 was very thin in stature with a weight of 120 pounds on admit, with an approximate eight to ten pound weight loss since then. It noted R113 laid down after breakfast and lunch, used a wheelchair for locomotion, had a foam cushion, and did not elevate the head of his bed. It identified R113 was turned every two hours but turns self back to supine and has an alternating air mattress. The note indicated on exam the coccyx ulcer measured 0.5 cm by 0.5 cm and the right sacral ulcer measured 2 cm x 1 cm; both stage II with scant exudates. The practitioner instructed to continue with the alternate air mattress overlay, lay down every two hours twice a day, try to alternate sides, and apply Mepilex Boarder four by four dressing to coccyx ulcer in a diamond shape, change every other day. Wound care was completed on 1/25/12 and was not due until 1/27/12. At 9:45 a.m. on 1/26/12 this	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 6 surveyor requested to observe R113 wound and dressing change. Wound care for R 113 was observed at 10:12 a.m. on 1/26/11 and the Mepilex Boarder dressing was not applied to wound. Nursing assistant (NA)-A verified the dressing came off that morning during morning cares. NA-A confirmed she reported that information to registered nurse (RN)-A. R113 was observed to be very thin and his coccyx protruded. The wound was approximately 0.3 by 0.2 with superficial depth. The surrounding skin appeared red and dry. CM-A reported the area was not warm to the touch and confirmed the area had some dry, flaking skin. CM-A applied a Zinc ointment and a Mepilex Boarder dressing to the area in the shape of a diamond. During interview at 10:32 a.m. on 1/26/11, RN-B stated she took over for RN-A at 9:30 a.m. and it was not passed on in report that R113's dressing came off during morning cares. During interview at 10:34 a.m. on 1/26/12 clinical manager (CM)-B verified the dressing should have been re-applied if it had fallen off. CM-B stated she expected that information to be passed on in report. CM-B verified the tissue tolerance was not completed and and should have been to determine appropriate timely repositioning intervention. CM-B confirmed the the tracking of the wounds were to be done weekly and that this was not completed for each identified pressure area. CM-B verified during the dressing change the surround area where the Zinc ointment and Mepilex Boarder dressing was applied was dry and verified that these treatments were intended to dry out moist wounds. CM-B stated the wound appeared drier than when she last applied the treatment but did not find this concerning enough to consult with the practitioner	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 7 to readdress if the current treatment was appropriate to promote healing of the wound. During follow-up interview at 10:48 a.m. on 1/26/12 NA-A stated the staff were expected to place a pillow behind R113's back when repositioning him side to side. NA-A stated R113 frequently moved himself back onto his back. During interview at 11:03 a.m. on 1/26/12, NA-D stated it was not her practice to place a pillow behind R113's back when turning him side to side. The Pressure Ulcer Risk Policy dated 9/11 indicated regardless of the residents total risk score each risk factor and potential causes should be reviewed individually. It instructed to implement interventions according to the Braden score and/or residents individual risk factors identified Wheelchair assessment R93 had multiple diagnoses including cerebral vascular accident (CVA). R93 was assessed by facility staff to be alert and oriented according to the most recent care conference review, dated 12/8/11. A review of the MDS (Minimum Data Set) and CAA (Care Area Assessment) dated 6/16/11, revealed no assessment for wheelchair positioning. Review of all assessments completed since 6/11 revealed no assessments were completed for wheelchair positioning. Review of the quarterly care conference documentation dated 12/8/11, 9/14/11, and 6/23/11 revealed wheelchair	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 8 positioning had never been addressed. On 1/23/12 at 7:30 p.m. and 1/25/12 at 8:00 a.m., R93 was observed to be slouched forward in the wheelchair. Observation on 1/25/12 at 2:00 p.m. revealed only minor changes in his positioning in the wheelchair. When asked, R93 was unable to position himself correctly in the w/c. At that time R93 was asked about his comfort level in the wheelchair. He stated "It's not the best in the west." R93 continued to say it would be better if he could "sit up a little bit better." Review of R93's record revealed no progress notes from therapy or nursing identifying the problem of wheelchair positioning. Interview with Clinical Manager-B (CM-B) indicated she was aware of his positioning issues with the wheelchair. "(R93) has always been a sloucher. I assumed he was comfortable. He never said anything to me." CM-B admitted she had never asked R93 about his wheelchair, but "I'll talk to him about it." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise policies and procedures pertaining to resident assessment to assure they comply with the regulations, retrain staff and develop a monitoring procedure. TIME PERIOD FOR CORRECTION: Fourteen (14) Days	2 540		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 9 must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on record observation, interview and document review, the facility failed to develop a comprehensive care plan related to contact precautions for 1 of 1 residents (R67) in the sample reviewed for infection control protocols. Findings include: R67 did not have a comprehensive care plan related to infection control precautions. R67 had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11, R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room since this date, according to the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12. During observations of care at 8:00 a.m. on	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 10 1/25/12, R67 was observed in a private room. Nursing assistant (NA)-A was observed to gown and glove prior to entering the room and indicated R67 was in isolation due to a c-diff infection. Review of the care plan identified the problem of R67's c-diff infection. The problem was initiated 1/11/12. The goal was for the resident to have no complications related to the infection. The care plan identified multiple interventions including to monitor the resident, education and disinfecting equipment used before it leaves the room. The care plan failed to identify the contact precautions, if the resident could leave the room and if so what needed to be done prior to the resident leaving the room, at what point the isolation precautions could be lifted, and what psychosocial things were going to be done while R67 was required to stay in her room. Clinical Manager (CM)-C stated at 10:20 a.m. on 1/26/12, the DON wrote R67's care plan. At 10:50 a.m. on 1/26/12 the DON stated "This was new to us [treating C-diff} so we're really working hard to get it right." After review of the assessment of R67's progress at 1:30 p.m. on 1/26/12, she stated "I guess I didn't add it to the actual care plan. I believe it was included [contact precautions] on the aide sheet." When the aide sheet was reviewed together, it failed to identify contact precautions but did identify the c-diff infection. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could provide education for the licensed staff regarding the importance of developing individualized care plans . The Director of Nursing could randomly audit resident charts to ensure the plans of care were	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 11 completed appropriately. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 555		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident's plan of care was revised as appropriate related to fall risk for 1 of 3 residents (R56) reviewed in the sample for accidents and related to an unavoidable sensory decline in vision for 1 of 1 residents (R56) reviewed in the sample for sensory problems. Findings include: R56 did not have her care plan revised to minimize the risk of further falls following a fall. In addition, the care plan was not revised according to R56's current visual limitations or to assist with maintaining or improving her independence as it related to a decline in vision. R56 had multiple diagnoses including transient	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 12 ischemic attacks (TIA's), glaucoma and diabetes. An annual minimum data set (MDS) completed on 8/3/11 and the quarterly MDS completed on 10/26/11, indicated R56 was cognitively intact with no signs or symptoms of psychosis. R56 also had no behavioral issues. The MDSs noted R56 had visual impairments but was able to read large print and was able to feed herself meals after the staff "set up" the meal. The MDSs also indicated that R56 had no history of falls. According to progress notes from 8/23/11 through 1/25/12, R56 is alert and oriented with minor forgetfulness. The forgetfulness increased with urinary tract infections (UTI's). R56 had a fall from bed at 1:45 a.m. on 1/20/12. According to the incident report and progress note from the fall, R56 stated she fell while trying to get up to go to the bathroom. R56 was being actively treated for a UTI at the time of the fall. Although R56 fell on 1/20/12, there were no interventions put in place to minimize the risk of further falls until 1/24/12. In the area of the incident report directing staff to document immediate interventions implemented, a low bed was identified by the LPN completing the report. However, R56 was already in a low bed at the time of the fall. When asked about the delay in interventions at 3:15 p.m. on 1/24/12, Clinical Manager (CM) B indicated she received the report on 1/23/12. After review, she had further investigation to do before bringing it to the interdisciplinary team (IDTeam) for review. On 1/24/12 CM-B was able to bring the incident report forward to the	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 13 IDTeam. At that time the team decided to implement a sensor pad alarm which would trigger the call light should R56 attempt to get up from bed independently. CM-B verified the above findings were accurate. When asked what was expected of the floor nurses when the incident occurred, CM-B indicated that the incident should be reviewed by the nurse with appropriate interventions implemented at the time of the incident. CM-B confirmed that the low bed was already in place at the time of the incident. Although a Fall Risk Evaluation had been completed on 1/24/12, it failed to identify R56's significant visual limitations and her acute UTI at the time of the fall. R56 was interviewed at 10:10 a.m. on 1/24/12. She indicated her vision had significantly declined in "the past few months." She further reported that at her last ophthalmology appointment "they (the physician) call me legally blind." R56 further stated she "used to" be able to make out the headlines and pictures in the newspaper, but she can no longer do that unless the headlines are "really big." R56 stated "They don't give me a lot of help at meals. I have a hard time feeding myself - getting the food on the fork and getting it to my mouth.' On 1/25/ 12 at 1:30 p.m. Nursing Assistant (NA) C indicated he was aware of R56's visual limitations. He stated "I ask her how she's doing and she always talks about - I'm losing my vision - I can't see that kind of thing." When interviewed at 1:15 p.m. on 1/26/12, Clinical Manager (CM) B indicated she was unaware R56 had significant limitations in her vision. She reported the first time she was aware	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 14 of the limitation was "yesterday in care conference." She further indicated that after discussion at the care conference, "dietary is going to get her a dark plate so she can see her food better. Part of what we talked about yesterday was to have dietary (staff) explain food and use clock method when the food is provided to her." The current plan of care identified visual limitations on 8/18/11. The goal was to maintain her ability to read large print through the review date of 2/2/12. R56 was no longer able to read most headlines in the newspaper. Further, according to the interview on 1/24/12 at 10:10 a.m. R56 struggled to eat independently, could no longer see to pick out her clothing and could make out large objects within her environment but was unable to determine what those objects were in most cases. R56's care plan failed to be revised with appropriate interventions to assist with the identified decline in vision. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions to meet the needs of residents A monitoring program could be established in order to assure on-going and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 15 care of the resident. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure each resident received care and services in accordance with their plan of care, related to refusal of pressure ulcer interventions for 1 of 4 residents (R91) reviewed in the sample for pressure ulcer. Findings include: R91 did not receive the pressure ulcer education as directed by her current plan of care dated as revised on 12/5/11. R91 had multiple diagnoses including multiple sclerosis (MS). An interview with case manager (CM)-B at 7:30 p.m. on 1/23/12 was completed and reported R91 was alert and oriented and currently had a stage II (partial thickness) pressure ulcer on her bottom which was a recurring problem. According to the interview with CM-B, R91 "heals up then opens up again and she's resistive with off loading." R91's current plan of care directed staff to "provide hourly off loading and repositioning as (R91) allows," "encourage (R91) to lay in bed or recliner between meals and activities," and "tilt wheelchair (w/c) slightly back for pressure relief." The care plan also indicated "Know (R91) is resistive with repositioning, especially at night." The care plan directed staff to educate (R91) on	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 16 the causes of breakdown including: transfer/position requirements, importance of taking care during ambulating/mobility, good nutrition and repositioning." During observations on 1/25/12-day shift, R91 was observed to not lay down from 7:10 a.m. until 2:25 p.m. This observation was confirmed by R91 as she stated "I'm busy." An interview with nursing assistant (NA)-B at 6:40 a.m. on 1/26/12 indicated R91's buttocks has "been like this forever" and verified R91 is resistive to most interventions but staff continued to offer. At 6:40 a.m. on 1/26/12, R91 stated "there's three nurses on me all the time" regarding interventions but R91 was unable to communicate consequences of refusals. During interview regarding the intervention of education regarding pressure ulcers at 2:10 p.m. 1/16/12, CM-B indicated "I know I haven't done a risk benefit (review of refusal of pressure ulcer interventions) with her on this. We've had conversations about the refusals but I don't know if I documented it." Review of R91's medical record revealed no documentation of education provided to R91 related to pressure ulcer prevention, development, interventions and consequences of refusals. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 17 directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not ensure each resident received the necessary care and services related to wheelchair positioning for 1 of 3 residents (R93) reviewed in the sample for positioning. The facility failed to ensure timely interventions to minimize the risk of falls for 1 of 3 residents (R56) reviewed in the sample for accidents. Findings include: R93 did not receive assistance with the identified problem of wheelchair positioning. R93 had multiple diagnoses including cerebral Vascular Accident (CVA). R93 was assessed by	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 18 facility staff to be alert and oriented according to the most recent care conference review, dated 12/8/11. Although R93 has been seen by Occupational Therapy in the past, R93 had never been seen by therapy for wheelchair positioning. At 7:30 p.m. on 1/23/12 and 8:00 a.m. on 1/25/12, R93 was observed to be slouched forward with pelvis pushed forward in wheelchair and a large gap between his back and the back of the wheelchair. In addition his pelvis was somewhat twisted in the chair with his left hip tight against the side of the wheelchair. Upon request at 7:30 p.m. on 1/23/12, R93 could independently adjust himself in the wheelchair, however he was unable to get his pelvis back and centered in the wheelchair. An interview with R93 was completed at 8:00 a.m. on 1/25/12 and was asked about his comfort level in the wheelchair. He stated "It's not the best in the west." R93 continued to report "it would be better if he could sit up a little bit better". When asked what he would like done differently about his wheelchair, he commented he thought a "little bigger chair" would be helpful. R93 indicated he would be receptive to assistance with wheelchair positioning as it would be "a little easier to sit in all day." Review of R93's record revealed no progress notes from therapy or nursing identifying the problem of wheelchair positioning. Interview with Clinical Manager (CM)-B indicated she was aware of his positioning issues with the wheelchair. "(R93) has always been a sloucher. I assumed he was comfortable. He never said anything to me." CM-B admitted she had never asked R93 about his wheelchair, but "I'll talk to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 him about it." Falls R56 had a fall which was not reviewed in order to ensure adequate safety interventions for 4 days. R56 had multiple diagnoses including transient ischemic attacks (TIA's), glaucoma, and was currently being treated for a urinary tract infection (UTI). According to consistent daily progress notes, R56 was assessed by the facility to be alert and oriented with forgetfulness which was worse when R56 had a UTI. The Fall Risk Evaluation completed 8/3/11, identified R56 to be at low risk for falls. The evaluation identified "will self transfer at times, forgetful, doesn't know limitations, extensive assist with transfers, doesn't always remember to use call light, raised edge mattress in place." The care plan initiated 8/18/11, identified limited physical mobility with a goal to "remain free from falls through the review date." The goal had been reviewed with an updated review date of 2/2/12. The care plan contained multiple interventions to maintain mobility and the safety interventions were "Raised edge mattress in place to orient her to bed parameters. Keep bed in lowest position to prevent injury. Reminder sign in place to remind (R56) to use call light and wait for assist. Provide verbal reminders of call light use with each application." R56 had a fall on 1/20/12 at 1:45 a.m. According to the incident report and progress notes for this date and time, R56 was attempting to get up and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 20 go to the bathroom. R56 got up from the window side of the bed and was found sitting on buttocks by bed. R56 normally gets up from bed on the side nearest the bathroom. The call light was within reach but was not used. In the section for immediate interventions following the fall, the completing LPN indicated "low bed" which was already in place at the time of the fall. This fall was not reviewed by the interdisciplinary team with interventions implemented until 1/24/12. According to Clinical Manager(CM)-B at 3:15 p.m. on 1/24/12, "Whoever the floor nurse is fills out the incident report and notifies family and physician. Then the incident reports go to the nurse manager and we discuss it in morning meetings, figure out interventions or we further investigate. Thursdays are the safety meeting. Therapy is not always at safety meeting but can call them and have them come down for a specific resident. We review all falls and interventions we put in place. If interventions are effective we close the incident report. If they're not effective or we have more to do, we leave the report open and continue to re-evaluate until we feel we came to a good solution." With regard to falls on Friday night or over the weekend, CM-B indicated "The nurse managers are on call but if there's nothing alarming, we review it Monday morning. We try and check in on the week end. They usually call us but sometimes they don't, so we call and check in and we may review it then." When asked why this fall waited for 4 days to be reviewed and have interventions put in place for safety, CM-B indicated that she had some questions regarding the fall and had to investigate on 1/23/12. She further stated that once her investigation was completed, she was able to review it with the interdisciplinary team on 1/24/12. CM-B indicated "We're going to put a	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 21 bed sensor pad on her bed which will trigger her call light if she gets up. (R56) is a little more forgetful - she got up on window side of the bed instead of the door side. In this case it did wait until Tuesday for intervention because it took me awhile to finish up the investigation." CM-B verified that R56 is " a little more confused" at night. The Fall Risk Evaluation dated 1/24/12, after the fall, identified R56 remained a low risk for falls. It should be noted that R56 was being treated for a UTI at the time of the fall, which was not included in the evaluation. Further, the evaluation failed to include R56's significant visual limitations - indicating only that her vision was "impaired - sees large print, but not regular print in newspapers/books." The bed sensor was observed to be added to R56's bed on 1/24/12 and had been added to the care plan. However, the care sheet utilized by the nursing assistants failed to include the addition of the sensory pad to the bed. During an interview with R56 at 10:25 a.m. on 1/24/12, R56 indicated she "forgot" to use the call light the night of the fall. She further indicated she's been having problems with incontinence, but the problem is improving since working with therapy on it. She further stated "when you gotta go, you gotta go" and she just wanted to get to the bathroom. "I hate to wet myself." SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all residents are properly positioned and residents at risk for falls have timely interventions implemented to minimize the risk. The director of nursing or her	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 22 designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. 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 pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and provide treatment to minimize the risk and promote healing of pressure ulcers for 1 of 3 residents (R113) reviewed for pressure ulcers and related to education including risks and benefits for 1 of 3 residents (R91) reviewed in the sample with a recurrent pressure ulcer. Findings include:	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 23 R113 was admitted on 11/25/11 with a stage I pressure ulcer on his coccyx which developed into two stage II pressure ulcers on12/18/11 and 12/20/11. R113 had diagnoses that included urinary retention, fatigue, severely under weight, advanced dementia with depression and anxiety, and a history of infection. The admission minimum data set (MDS) dated 12/2/11 identified R113 had no cognitive impairments, no behaviors, and required extensive assistance of one staff for repositioning. The MDS indicated R113 was at high risk for pressure ulcer development and did not have one or more unhealed pressure ulcers at a stage I or higher. The MDS revealed skin and ulcer treatments included a pressure reducing device for his chair and bed, a turning and repositioning program, and application of ointments/medication other than to his feet. The admission initial nursing data form dated 11/25/11 identified R113 had a reddened coccyx and a tissue tolerance was to be completed. R113's tissue tolerance observation for the lying position dated 11/25/11 identified staff observed his current skin integrity after two hours and redness was noted on his coccyx. The observation form then instructed staff to re-observe after one and a half hours. The observation form asked after one hour was the redness noted over the boy prominence's which the facility identified as "Yes, the area remained red, initiate wound care protocols stage I and redo the observation at 1 hour." R113's tissue tolerance for sitting observation dated 11/25/12	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 24 read "Unable to assess - resident in lying positioning through-out shift." The facility did not initiate wound care protocols for a stage I pressure ulcer to monitor the area and did not assess R113 for tissue tolerance while sitting to determine appropriate interventions for repositioning needs. A tissue tolerance skin risk factor evaluation form dated 12/1/11 noted R113 was at mild risk for skin breakdown. It identified he had a bio foam mattress and pressure redistribution cushion in wheelchair. It noted he "has a reddened coccyx which was present upon admit" and to apply barrier cream to this area twice daily. R113's plan of care, dated 12/13/11, identified he had a stage I pressure ulcer on his coccyx related to immobility and low body weight. The interventions included the application of barrier cream to his coccyx and that he was turned and repositioned throughout the day and repositioned during routine rounds on the night shift. It also identified he was to utilize a biofoam mattress and pressure redistribution cushion in his wheelchair. On 12/18/12 the care plan was updated to include an air mattress overly to the bed. On 12/18/11, a weekly wound documentation form was initiated for a stage II pressure ulcer on R113's coccyx. The form indicated R113 had a stage II pressure ulcer on his coccyx measuring 1.5 cm by 1.5 cm by 0.2 cm, with no draining or odor. The treatment included an Allevyn foam dressing and Tena with Zinc. On 12/23/11 the wound was noted to be stable, and was reassessed as a stage II pressure ulcer measuring 0.2 cm by 0.1 cm by 0.1 cm, with the same treatment. On 12/30/11 the wound was	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 25 noted to be improving, and was reassessed as a stage II pressure are measuring 0.4 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/8/12 the wound was noted as stable and was reassessed as a stage II pressure are measuring 0.6 cm by 0.2 cm by 0.1 cm, with the same treatment. On 1/17/12 the area was assessed by the wound care practitioner. On 12/20/11, a weekly wound documentation form was initiated for a stage II pressure ulcer identified on the diagram as located on the lower area of the buttock and noted as a "lower open area." The form indicated R113 had a stage II pressure ulcer on his lower buttock measuring 1.8 cm by 1.2 cm by 0.1 cm, with no draining or odor. The treatment included an Duoderm dressing. On 12/25/11 the wound was reassessed as a stage II pressure ulcer measuring 0.2 cm by 1.5 cm with no depth with 100% granulation. At this time an Allevyn foam dressing and Tena with Zinc treatment was applied and the area was noted as improved. On 1/24/12 the wound was reassessed as a stage II pressure area measuring 0.3 cm by 0.2 cm with no depth, the area was noted as dry, the treatment was changed to Mepilex Boarder and was identified as improved. On 1/17/12 the area was assessed by the wound care practitioner. No further documentation was provided to indicate that the area was monitored or assessed from 12/25/11 to 1/17/12. The physician orders and progress notes form dated 1/17/12 identified a wound care consult was completed. The note indicted R113 had stage II skin breakdown on his sacrocoxygeal area for approximately two weeks. The note identified R113 was very thin in stature with a weight of 120 pounds on admit, with an	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 26 approximate eight to ten pound weight loss since then. It noted R113 laid down after breakfast and lunch, used a wheelchair for locomotion, had a foam cushion, and did not elevate the head of his bed. It identified R113 was turned every two hours but turns self back to supine and has an alternating air mattress. The note indicated on exam the coccyx ulcer measured 0.5 cm by 0.5 cm and the right sacral ulcer measured 2 cm x 1 cm; both stage II with scant exudates. The practitioner instructed staff to continue with the alternate air mattress overlay, lay down every two hours twice a day, try to alternate sides, and apply Mepilex Boarder four by four dressing to coccyx ulcer in a diamond shape, and to change this dressing every other day. Wound care was completed on 1/25/12 and was not due until 1/27/12. At 9:45 a.m. on 1/26/12, this surveyor requested to observe R113 wound and dressing change. Wound care for R113 was observed at 10:12 a.m. on 1/26/11 and the Mepilex Boarder dressing was not applied to wound. Nursing assistant (NA)-A verified the dressing came off that morning during morning cares. NA-A confirmed she reported that information to registered nurse (RN)-A. R113 was observed to be very thin and his coccyx protruded while his buttock tissue appeared to sag and sink in giving the appearance of no buttock. The wound was approximately 0.3 by 0.2 with superficial depth. The surrounding skin appeared red and dry. CM-A reported the area was not warm to the touch and confirmed the area had some dry, flaking skin. CM-A applied a Zinc ointment and a Mepilex Boarder dressing to the area in the shape of a diamond. During interview at 10:32 a.m. on 1/26/11 RN-B stated she took over for RN-A at 9:30 a.m. and it	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 27 was not passed on in report that R113's dressing came off during morning cares. During interview at 10:34 a.m. on 1/26/12, clinical manager (CM)-B verified the dressing should have been re-applied if it had fallen off. CM-B stated she expected that information to be passed on in report. CM-B verified the tissue tolerance was not completed and should have been used to determine appropriate timely repositioning intervention. CM-B confirmed the tracking of the wounds were to be done weekly and this, was not completed for each identified pressure area. CM-B verified during the dressing change, the surrounding area where the Zinc ointment and Mepilex Boarder dressing was applied was dry and verified that these treatments were intended to dry out moist wounds. CM-B stated the wound appeared drier then when she last applied the treatment but did not find this concerning enough to consult with the practitioner to readdress if the current treatment was appropriate to promote healing of the wound. During follow-up interview at 10:48 a.m. on 1/26/12, NA-A stated the staff were expected to place a pillow behind R 113's back when repositioning him side to side. NA-A stated R113 frequently moved himself back onto his back. During interview at 11:03 a.m. on 1/26/12 NA-D stated it was not her practice to place a pillow behind R113's back when turning him side to side. The Pressure Ulcer Risk Policy, dated 9/11, indicated regardless of the residents total risk score each risk factor and potential causes should be reviewed individually. The policy also instructed staff to implement interventions	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 28 according to the Braden score and/or resident's individual risk factors that were identified. R91 did not receive the services to promote healing and minimize the risk for development of pressure ulcers. R91 had multiple diagnoses including Multiple Sclerosis (MS). The Braden Scale Pressure Ulcer Risk Assessment, dated 12/1/11, identified R91 to be at mild risk for pressure ulcer development. The most recent tissue tolerance review completed by the facility in 11/11, identified the need for hourly off loading and repositioning had been initiated. The care plan dated as revised on 12/5/11 identified recurrent pressure ulcers as a problem and identified resident resistance to off loading but staff was to continue to offer and educate the resident. An interview with CM-B at 7:30 p.m. on 1/23/12, revealed R91 currently had a stage II (partial thickness) pressure ulcer to her buttocks, which is a recurring problem. "She heals up, then it opens up again - she's resistive with off loading." Observation during interview at 7:00 p.m. on 1/23/12, revealed R91 leaned all the way back in her recliner. Throughout the 20 minute observation, R91 made no attempt to shift position in the recliner and indicated staff assisted her with repositioning as needed. During observations on 1/25/12 day shift, R91 was observed to not lay down from 7:10 a.m. until 2:25 p.m. This observation was confirmed by R91 as she stated "I'm busy."	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 29 An interview with NA-B at 6:40 a.m. on 1/26/12, indicated R91's buttocks has "been like this forever" and verified R91 was resistive to most interventions but staff continued to offer. An observation at 6:40 a.m. on 1/26/12, revealed R91's pressure ulcer was on the left buttock fold and scabbed over with a macerated peri wound surrounding the scabbed area. There were multiple deep indentations from the bedding in her buttocks, back and legs. R91 and NA-B indicated she preferred not to reposition during the night shift as it disrupted her sleep. Although R91 consistently refused pressure ulcer interventions, staff was aware of the refusals, and the plan of care directed staff to educate her on pressure ulcers, there was no evidence of this education in the resident record. When asked at 6:40 a.m. on 1/26/12, R91 stated "there's 3 nurses on me all the time" regarding interventions but was unable to communicate consequences of refusals. During interview regarding the intervention of education for pressure ulcers on at 2:10 p.m. on 1/16/12, CM-B indicated "I know - I haven't done a risk benefit (review of refusal of pressure ulcer interventions) with her on this. We've had conversations about the refusals but I don't know if I documented it." Documentation on the "Weekly Wound Documentation Form" on 1/8/12 identified a stage II (partial thickness) pressure ulcer on the right gluteal fold, which was pink in color with no drainage. The ulcer measured 0.9 cm x 1.5 cm and staff indicated barrier cream was applied. On 1/11/12 the form identified "no change" and indicated the ulcer measured 0.9 cm x 1.4 cm.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 30 Staff indicated on 1/15/12, the stage II pressure ulcer measured 0.9 cm x 1.7 cm and had 100% granulation (healthy) tissue with moderate drainage. The note further identified the ulcer was larger in size and had declined. On 1/18/12, the flow sheet identified the ulcer had improved and measured 0.9 cm x 0.9 cm. The flow sheet further indicated the pressure ulcer had scabbed over and staff continued to use barrier cream. The flow sheet indicated on 1/25/12 that there was no drainage and the pressure ulcer measured 0.7 cm x 0.8 cm and had scabbed over. At 8:00 a.m. on 1/26/12, NA-B informed the nurse that when she was providing care to R91's bottom, the "scab came off" her buttocks and there was no longer an open area. The most recent previous pressure ulcer was documented in progress notes as healed on 11/27/11. The pressure ulcer was identified to her coccyx and was first observed on 11/21/11. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 31 deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident was provided with appropriate treatment and services to maintain or improve their abilities related to an unavoidable sensory decline in vision for 1 of 1 residents (R56) reviewed in the sample for sensory problems. Findings include: R56 had a significant decline in vision without intervention. R56 had multiple diagnoses including glaucoma, diabetes, and diabetic retinopathy. The care area assessment (CAA) for vision, dated 8/17/11, indicated R56 had impaired vision due to difficulty reading regular print but was able to read large print and see objects in the environment. The assessment failed to include the diagnoses of glaucoma, history of cataracts or transient ischemic attack (TIA), both of which	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 32 could contribute to a visual decline. The most current nutrition assessment completed 11/2/11, identified R56 as sighted with no problems feeding self. The current care plan, revised 11/11, identified impaired vision. The established goal was to maintain the ability to read large print. The approaches included "Monitor/document/report to MD the following signs/symptoms of acute eye problems: Change inability to perform ADL's (Activities of Daily Living), decline in mobility, sudden visual loss, pupils dilated, gray, or milky, complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision." The care plan did not identify any assistive devices for improving her vision or assisting R56 to maintain her independence. R56 had ophthalmology visits on 5/17/11 and 11/17/11. She was identified with open angle glaucoma in both eyes and pseudophakia in both eyes. The physician noted the onset to be gradual and no change in treatment was recommended. R56 was interviewed at 10:10 a.m. on 1/24/11, her vision had significantly declined in "the past few months." She further indicated that at her last ophthalmology appointment "they [physician]call me legally blind." She reported to" be able to make out the headlines and pictures in the newspaper, but she can no longer do that unless the headlines are "really big." R56 stated "They [facility staff] don't give me a lot of help at meals. I have a hard time feeding myself - getting the food on the fork and getting it to my mouth.' When asked if she's talked with therapy about her problems maintaining independence at meals or if any adaptive equipment had been offered, R56	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 33 stated "No, they've never given me anything like that." During an interview at 1:50 p.m. on 1/25/12 , R56 verbalized that wanted to make certain staff understood she wanted to remain as independent as possible and stated "I like to be independent. I just really want to do things for myself as much as I can. I don't want everyone to know I can't see. The aides know - they pick out my clothes for me in the morning." On 1/25/ 12 at 1:30 p.m., nursing assistant (NA) -C indicated he was aware of her visual limitations. He stated "I ask her how she's doing and she always talks about losing her vision" and that she "can't see" When interviewed at 1:15 p.m. on 1/26/12, Clinical Manager (CM)-B indicated she was unaware R56 had significant limitations in her vision. She indicated the first time she was aware of it was "yesterday in care conference." She further indicated that after discussion "Dietary is going to get her a dark plate so she can see her food better. I should make her an eye appointment to get her vision checked. I wasn't aware her sight was that bad. Her last ophthalmology appointment was 11/17/11 - there was nothing specific about visual ability. Part of what we talked about yesterday was to have dietary explain food and use clock method when the food is provided to her." SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the care and services for residents with a visual decline. The DON or designee (s) could provide training for all appropriate staff on	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 34 these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 915		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to store food service equipment in a sanitary manner to prevent the transmission of food bourne illness and physical contamination to food, having the potential to affect 70 of 70 residents who ate at the facility. Findings include: During the initial kitchen observation at 1:33 p.m. on 1/23/12, the Hobart meat slicer was stored on the counter top covered and was considered clean. The meat slicer had an accumulate of food residue on the blade rotator and sharpener component, which was an area in which food came in contact with when slicing. The stove hood vents, situated above the grill and open cooking range, were soiled with a brown/black substance and thick layer of dust build up.	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 35 An Edmund industrialized sized can opener was attached to the end of the steam table area. The can opener blade was dull and had metal chard's behind the blade. Dietary manger (DM) confirmed these observations. During interview at 1:42 p.m. on 1/23/12, Cook-A confirmed the meat slicer was last used yesterday for slicing roast beef. Cook-A demonstrated how to take apart the meat slicer for cleaning. Cook-A stated she was unaware the sharpener component, the area in which had an accumulate of food residue, was removable for cleaning and sanitizing. During interview at 1:44 p.m. on 1/23/12, DM stated staff were to take apart the meat slicer after every use, clean and sanitize the machine and send the detachable components through the dishwasher, including the sharpener component. DM reported she was unsure the last time the blade was changed on the industrial sized can opener because it was rarely used but confirmed staff used it on occasion. During a follow-up observation at 7:32 a.m. on 1/25/12, Cook-B was asked to disassemble the meat slicer, which was covered and considered clean. Cook-B detached the sharpener competent. The blade rotator situated under the sharpener component had a build up of food residue. Cook-B confirmed the observation and without cleaning or sanitizing the machine, reassembled the machine and covered it for the next use. Cook-B reported the meat slicer was used one to two times a week to slice meats. During a follow-up observation at 1:35 p.m. on 1/26/12, DM was asked to disassemble the meat	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 36 slicer, which was covered and considered clean. DM detached the sharpener competent. The blade rotator situated under the sharpener component had a build up of food residue. DM stated she asked staff to clean and sanitize the machine after the first observation on 1/23/12 but did not follow-up to monitor if the task was done appropriately. DM verified the stove hood vents had not been cleaned and still contained brown/black substance and thick layer of dust build up. DM stated she did not have the vents cleaned because "they were just cleaned on the fourth." DM further stated if she observed something that was soiled or dirty it would be cleaned. DM stated the stove hood vents should have been cleaned after the initial observation and may need to be cleaned more frequently to prevent dust build up. The Hobart meat slicer instructions for cleaning dated 2/01, identified the meat slicer had a top knife cover (sharpener component) that contained the meat slicer sharpener. The instructions indicated the meat slicer machine must be thoroughly cleaned and sanitized after each day's operation or after being idle for an extended period of time. It instructed to remove the sharpener and top knife cover. It identified the top knife cover, deflector and the sharpener housing unit (also part of the sharpener component) needed to be wiped out with no residue remaining inside the sharpener housing unit and on the blade and clean the sharpener in a sink. It instructed to rinse with fresh water and to not wash the slicer components in the dishwasher R42 obtained ice for ice water from the large ice machine in the North Dining Room without practicing good infection control technique,	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 37 potentially contaminating the ice machine. At 1:00 p.m. on 1/25/12, R42 entered the dining room to get ice for water. She took the scoop out of the bin and set it on the counter. R42 walked to the sink and dumped part of water from the pitcher. R42 went back to the ice machine with the pitcher. Holding the water pitcher inside of ice machine, R42 used the public scoop to place ice inside of her pitcher coming in contact with pitcher. R42 packed the ice down with the scoop and added more ice again coming in contact with the pitcher. R42 placed the scoop in the ice machine while she set the pitcher down on her walker. R42 then returned the scoop to the plastic bin for ongoing use. At that time R42 verified the pitcher was hers that she had been using the pitcher "since yesterday. I get my own ice water every day. The staff is just so busy." Although there were 4 staff members in the dining room at the time of this incident, no staff intervened with the practice. Nursing Assistant (NA)-C at 1:30 p.m. on 1/25/12 stated "I saw her come in and get her ice. She's really clean. As long as they (residents) wash their hands and stuff, it hasn't been a problem. She's a really clean person. She always gets her own (ice). I've never noticed it to be a problem." When the observation was described to the Infection Control Nurse and the Director of Nursing (DON) at 12:45 p.m. on 1/26/12, the DON stated she would work on this issue as it was "not my first choice" for practice. SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 38 regarding proper cleaning of kitchen equipment. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment. TIME PERIOD FOR CORRECTION: 15 (fifteen days)	21015		
21045	Mn Rule 4658.0620 Subp. 4 Frequency of Meals; Dining Room Subp. 4. Dining room. Meals are to be served in a specified dining area consistent with the resident's choice and plan of care. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that residents had choices related to food and snacks for 5 of 5 residents (R25, R67, R56, R46, R28) in the sample reviewed for choices. Findings include: R46 reported during an interview at 10:55 a.m. on 1/24/12, that dietary staff " just serves the meal " and does not feel that she was given a choice of foods at meal times. R46 reported " would like to have a choice of food that she eats. " R46 had multiple diagnoses, including above the knee amputation, esophageal reflux, persistent mental disorder, and depressive disorder. An annual minimum data set (MDS) was completed on 8/3/11 and a quarterly MDS was done on 10/27/11. Both MDSs indicated R46 was	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 39	21045		

cognitively intact with no signs or symptoms of delirium, psychosis or any behavioral issues. She had no communication barriers and was generally independent with eating after staff set up her meals.

R46 was again interviewed at 8:09 a.m. on 1/25/12. She was eating her breakfast and reported that she was not satisfied with breakfast served as food was cool. She Indicated that she would talk to dietary staff about this but no dietary staff were available.

R46 was interviewed again at 1:05 p.m. on 1/25/12. Resident was sitting at a table in the dining room with her noon meal in front of her. She was not eating and appeared upset. She reported that she did not like what was served. She indicated the carrots were cold and she did not like the pork patty. Again, she reported she would have told the dietary staff about this and requested an alternative, but no dietary staff was available.

An interview was completed with Dietary Aide (DA)-A, who reported an alternate was available to all residents if they do not like what was served for the main entrée. DA-A indicated the alternate was not posted and so residents do not know what the alternate would be. If a resident voices that they do not like the main entrée, dietary staff will request an alternate from the cook. DA-A reported that soup and sandwiches are always available to residents at their request.

An interview was completed with the Dietary Manager at 12:34 p.m. on 1/25/12. She reported that she was unaware of R56 ' s complaint of not having choices for meals. The DM did report R56 did have problems asserting herself at times and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 40 if she was dissatisfied with food served, may not say anything to staff. The DM reported that at the present time, the facility had a fairly passive population, who may not report any concerns they have. The DM did indicate that after the meal was served, dietary staff do not check with residents regarding their meal satisfaction and so she did verify that there would not be any dietary to tell if they did not like what was served. An interview with registered nurse Clinical Manager (CM) C was completed at 1:15 p.m. on 1/25/12. CM-C reported that R56 had not voiced any complaints regarding not having choices for food or any dissatisfaction regarding food choices. CM-C did indicate that if R56 had any concerns, she would generally talk to her daughters, who would bring the issue to the nursing staff. CM-C reported " R56 does have a hard time voicing concerns. " R28 was not provided the dietary plan requested by family members. A telephone interview was completed at 11:25 a.m. on 1/24/12 with R28 ' s family-A, who reported that the family was very concerned regarding R28 ' s weight gain since admission to the facility. Family-A stated that R28 had gained 8 pounds in the recent past and she had talked to the facility ' s Dietary Manager about this. Family -A indicated they had requested R28 not receive any " sugary snacks " but the ' facility does not seem to get it ' and continues to provide sugary snacks during snack pass. " Family-A stated she and her sister had requested R28 be given a piece of fruit at snack time. Family-A reported that her mother will eat whatever anyone gives her too eat and even if R28 was full, will eat it until it is gone.	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 41 R28 had a current diagnosis that included dementia, carcinoma of unspecified part of intestine, abnormality of gait, atrial fibrillation and hypothyroidism. According to the significant change MDS, completed on 12/29/11, R28 had both long and short term memory issues and was severely cognitively impaired. She had problems understanding and making self understood at times. She needed extensive assistance of 2 facility staff for ADLs (activity of daily living) and needed limited assistance of one staff at mealtime. An interview was completed with the Dietary Manager (DM) at 12:34 p.m. on 1/25/12, who reported she was aware that family was very concerned regarding resident ' s weight gain. DM reported that she had negotiated with the family to put resident on " small portions " and since doing this, R28 had " lost a few pounds " . DM indicated she did not feel that it was " right to withhold sugary snacks " from R28 and reported she was under the impression the family was accepting of the small portions to R28 ' s diet and were willing to bypass the ' fruit only for snack ' request. The DM did report that R28 was unable to make personal choices regarding meal choices and ate whatever staff gave her. R25 did not receive an opportunity for choice at snack times. During interview at 6:30 p.m. on 1/23/12, R25 stated "I get hungry in between meals. I'd like something that will tide me over - like a half sandwich or something-nothing sweet."	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 42 At 2:15 p.m. on 1/25/12, R25 indicated she had told nursing staff she gets hungry between meals and she did not like sweets but she hasn't seen anything done about the report yet. R25 had multiple diagnoses including pyelonephritis and malaise/fatigue. The Minimum Data Set (MDS) dated 12/23/11 identified R25 as alert and oriented. An observation of the snack cart at 8:00 p.m. on 1/23/12 revealed cookies as the primary snack with substantial snacks of sandwiches provided to specific residents. The cart also contained juice. When asked at 2:00 p.m. on 1/26/12, Clinical Manager(CM) B indicated R25's request came up in care conference in 12/11. CM-B stated "We told her there's always sandwiches or snacks available, she just has to ask. There's always sandwiches on the cart and I wonder why she (R25) doesn't know that. Sometimes the kitchen has made special snacks for people - they would make one especially for the resident. I don't think we talked about just sending her up something - it just came up briefly." An interview at 9:30 a.m. on 1/26/12 with the Dietary Manager (DM) was completed. The DM reported she was unaware of the R25's request. The DM also stated "They (the residents) just need to ask." R67 did not receive an opportunity for choice at meal times. R67 had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11 R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 43	21045		

causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room, according to the Director of Nursing (DON) during an interview at 1:30 p.m. on 1/26/12.

At 9:00 a.m. on 1/25/12, R67 received her breakfast tray from staff of scrambled eggs, cereal and yogurt. Staff left room after setting up R67's tray. There was no offer of choice prior to the staff member leaving the room. R67 indicated she was "so tired of eggs". R67 clarified she "will eat a soft egg - like a fried egg - but sick of scrambled eggs. I got them every morning for 5 months at my previous place. That was a nice place - you could choose what you wanted to eat." When asked if she got choices with her meals now, R67 stated "No, not at all. You get what you get."

According to Clinical Manager (CM) C at 10:30 a.m. on 1/26/12 , "(R67) is informed at care conferences and resident council to ask for something different if she doesn't like it. There's always second choices-she has asked for something different when she doesn't like it." R67 stated at 10:50 a.m. on 1/26/12 "I've been in this room a long time. There's not always someone to tell if I don't like it." R67 further stated she was "not fussy but it would be kind of nice to have some options."

R56 was not offered an opportunity for choice at meal times.

Upon interview at 10:10 a.m. on 1/24/12, R56 indicated there was no choice for meal selection at meal time. She stated "When I don't like it,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 44 you're stuck with it." R56 had multiple diagnoses including Diabetes and Glaucoma. R56 was assessed by staff as alert and oriented with minor forgetfulness according to progress notes. Observation of the lunch meal in the north dining room on 1/25/12 revealed R56 did not eat her meat. There was no staff available in the dining room for residents to ask for an alternate selection. An interview with R56 at 1:50 p.m. on 1/25/12 indicated "I don't care for pork. I thought it was fish. I only had a bite. I didn't care for it. They didn't offer me anything else. I just ate the potatoes. They never ask (if I would like something different)." Interview with the Dietary Manager (DM) at 9:30 a.m. on 1/26/12 indicated "(R56) had never told me she didn't like pork." The DM indicated residents need to indicate they do not like something in order to get something different. When asked how resident's were supposed to report it when there was no staff available in the dining room to tell, the DM stated "Good point - there are no staff to tell if they don't like the food served." The DM also indicated that residents can review the posted menu on their way through the door and if they don't like something just let someone know and they will provide a substitute prior to the resident's food being served. When asked how resident's can review the menu if they are unable to visualize the menu or can't read the DM again stated "residents can tell staff they don't like the food being served and they would be offered something else." "We always have leftovers available in the freezer or soup and sandwich available."	21045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21045	Continued From page 45 When interviewed at 2:20 p.m. on 1/26/12, Clinical Manager(CM) B indicated she was unaware R56 was having an issue with choices at meal time. "She's pretty good about making her needs known." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and the Director of Dietary Services could schedule an in service for all nursing and dietary staff to stress the importance of offering each resident choices of food at meal times and snacks. The quality assurance committee could establish a system to audit staff to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21045		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement and maintain an infection control program to help prevent the development and transmission of infections, failure to follow the recommendations for hand hygiene, appropriate implementation of contact precautions, and proper sanitation of cleaning equipment. This deficient practice had the potential to effect all 70 residents who resided in the facility.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 46 Findings include: Although R67 was in contact precautions, staff did not consistently utilize the contact precautions appropriately as directed by facility policy. R67 did not have a comprehensive care plan related to infection control precautions. R67 was admitted to the facility on 11/2/11. She had multiple diagnoses including diabetes and was experiencing intermittent loose stools. On 12/30/11, R67 was diagnoses with clostridium difficile (c-diff) in her stools (a bacterium that causes infectious diarrhea as well as more serious intestinal conditions). R67 was placed in a private room in contact isolation on 12/29/11 due to the suspected c-diff infection. R67 was not allowed to come out of her room according to the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12. At 9:05 a.m. on 1/25/12, R67 was served her breakfast tray. Nursing Assistant (NA)-A entered the room without donning personal protective equipment (PPE). NA-A set up R67's tray, placed it on the over-bed table, touching the table with her hands and brushing against it with her uniform. NA-A then assisted R67 to wash her hands, placed sanitizing gel in her own hands and applied the gel onto R67's hands, assisted resident to wash her hands prior to eating. NA-A placed the spoon in R67's hand. NA-A then left R67's room, utilizing sanitizing gel to her own hands. NA-A left the room to get a clothing protector and straws. NA-A again entered the room with no PPE, placed straws in R67's drinks and placed the clothing protector around R67 coming in contact with R67 and the wheelchair with her hands and uniform. NA-A left the room	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 47 again, this time without washing her hands. She went to the food tray cart, which was stationed in the hallway by R67's room, to obtain jelly from a public bowl of jelly on top of the cart. NA-A returned to the room with the jelly without washing hands or donning PPE. She then finished setting up the breakfast tray for R67. NA-A did not wash hands upon leaving the room. An interview with NA-A at 9:20 am on 1/25/12, indicated she was told "only have to gown/glove when coming body to body contact." She clarified that touching items in the environment wouldn't have been a concern. It's "only if you touch the resident." When asked specifically about touching the resident's hands to wash them and her body to place the clothing protector NA-A stated "Oh yeah you're right I should have put on gloves." NA-A was asked about when to wear a gown and she reported she didn't need to wear one. "Only when doing cares and body to body contact." At 9:35 a.m. on 1/25/12, clinical manager (CM)-A stated "Staff should gown and glove when in direct contact with the resident - although the hands I'm thinking maybe it's not an issue." Explained to CM-A that NA-A washed the residents hands and brushed up against w/c and tray table. CM-A stated "I will check with (the Infection Control Nurse) to be sure what our policy is. She should be washing her hands when she comes into the room and when she leaves the room - foam in foam out." When asked what should be done with the food cart, specifically the bowl of jelly that was potentially contaminated by the infection control breach, CM-A stated "I'm not sure what we would do with the jelly. I will check with (the infection control nurse) and let you know." At 9:50 CM-A returned and verified NA-A should have gowned and gloved if she's brushing	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 48 up against the resident and wheelchair and touching the resident. When asked what was going to be done with the food cart and the jelly CM-A stated "We should throw away the jelly and wash the bowl obviously." When informed the cart and the jelly remained in the hall for use, CM-A stated "Oh, I'll go get rid of it right now and we'll talk to (NA-A). Interview with the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12 verified this incident was a breach in their infection control practice. They further indicated NA-A had been re-educated and they would re-educate other staff as well on the infection control protocols including contact precautions. The facility policy "Contact Precautions" dated 1/08 and provided by the DON as current indicated "Gloves should be worn when entering the room and while providing care for a resident." The policy further directed staff to wash their hands after glove removal and "hands should not touch potentially contaminated environmental surfaces or items." The policy indicated gowns should be worn "if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the room." The policy did not identify the term "substantial". According to the DON at 12:45 p.m. on 1/26/12, she would consider substantial to be if the staff member was going to physically come in contact with the resident or the environment. Although the policy identified "Patient Transport" there was no definition of when a resident may come out of their room or what precautions needed to be taken to do so Hand hygiene was not completed after handling a soiled dressing, removing gloves and proceeding	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 49 to apply a clean dressing during R113's observed dressing change for an open stage II coccyx pressure ulcer. During observation at 10:12 a.m. on 1/26/11, clinical manger (CM)-A provided wound care treatment for R113. CM-A washed then gloved her hands, soaked a gauze with normal saline and cleansed R113's coccyx area, wiping around the wound and wound bed, which had a zinc ointment applied. CM-A then took off the glove on her right hand, pulled a glove out her scrub pocket, and placed the glove on her right hand. CM-A was asked if it was her practice to use gloves stored in her scrub pocket at which time, CM-A then ungloved her hands, threw them away, and went into the bathroom to change her gloves. CM-A did not complete hand hygiene after handling soiled gauze and changing her gloves. CM-A confirmed she did not perform hand hygiene after handling the soiled gauze with gloved and after changing her gloves. CM-A stated it was not her practice to complete hand hygiene after handling the soiled gauze and changing gloves when completing a dressing. The Centers for Disease Control (CDC) identifies that hygiene continues to be the primary means of preventing the transmission of infection. The CDC identified hand hygiene was required after handling soiled dressings and after removing gloves. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 50 Time Period for Correction: Twenty one (21) days.	21375		
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived. Conditions of Waver: - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease.	21400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21400	Continued From page 51 This MN Requirement is not met as evidenced by: Based on interview and document review the facility did not maintain a record of each resident's admission Tuberculosis skin test results, including measured induration for 5 of 6 residents (R67, R85, R115, R78, and R3) reviewed in the sample for immunizations. Findings include: Although R67, R85, R115, R78, and R56 had their mantoux tuberculosis tests administered and read, the facility failed to document the induration results on all 5 residents. Current Centers for Disease Control (CDC) guidelines indicated that millimeters of induration should be documented for all mantoux results. If there is no induration, it is recommended that "0 mm" is documented. R67 was admitted on 11/18/11. She had her first step mantoux administered on 12/3/11 and read on 12/5/11. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 12/10/11 and read on 12/12/11. The results indicated negative but failed to provide any measurement of induration. R85 was admitted on 11/29/11. She had her first step mantoux administered on 11/30/11 and read on 12/2/11. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 12/7/11 and read on 12/9/11. The results indicated negative but failed to	21400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21400	Continued From page 52 provide any measurement of induration. R115 was admitted on 1/6/12. He had his first step mantoux administered on 1/7/12 and read on 1/9/12. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 1/15/12 and read on 1/17/12. The results indicated negative but failed to provide any measurement of induration. R78 was admitted on 1/5/12. She had her first step mantoux administered on 1/6/12 and read on 1/8/12. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 1/13/12 and read on 1/15/12. The results indicated negative but failed to provide any measurement of induration. R3 was admitted on 4/11/11. She had her first step mantoux administered on 4/12/11 and read on 4/14/11. The results indicated negative however failed to provide any measurement of induration. The second step mantoux was administered on 4/19/11 and read on 4/21/11. The results indicated negative but failed to provide any measurement of induration. Interview at 1:15 p.m. on 1/25/12 with Clinical Manage-C (CM-C), RN-D and RN-E indicated they don't measure the millimeters of induration when the mantoux result is negative. Interview with the Director of Nursing (DON) and Infection Control Nurse at 12:45 p.m. on 1/26/12 verified it was not something they have asked the staff to do. They further indicated "if we had known we had to it would have been easy to do." Review of the facility policies for staff and resident tuberculosis prevention and mantoux	21400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21400	Continued From page 53 administration dated 8/09 and provided by the facility as current, the policies failed to direct staff to include the millimeters of induration when documenting mantoux results. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure Tuberculosis skin test are done appropriately. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21400		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 54 not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that each resident's medication regimen was free of irregularities related to the administration of Lanoxin (digoxin, a cardiac medication) without regular monitoring of the pulse for 1 of 10 residents (R91) reviewed in the sample for unnecessary medications. Findings include: R91 did not have the irregularity of digoxin administration without the monitoring of pulse identified by the monthly pharmacist's drug review. R91 had multiple diagnoses including atrial fibrillation. R91 had a Physician's order for Lanoxin (digoxin) 0.25 mg by mouth every day. The order dated back to admission on 6/6/11. R91 was admitted with facility standing orders which included an order to hold the administration	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 55 of digoxin if pulse less than 55. Review of the medication administration records (MAR's) revealed there was no pulse documented for the months of 11/11, 12/11, or 1/12. There was also no information on the MAR directing the facility staff to hold the digoxin for a pulse less than 55 or a prompt to take the pulse prior to administration. Interview with RN-C on 1/26/12 at 8:15 a.m. revealed "I don't know why we don't take her pulse anymore. I'm thinking we used to but we don't do it anymore - but I don't know why. It's fallen off for a few residents where we used to do it and now we don't anymore." Clinical Manager-B (CM-B) on 1/26/12 at 8:30 a.m. indicated she had no additional information and verified the orders were accurate and the pulse should have been taken prior to administration of the digoxin. Review of the monthly pharmacy reviews for medication irregularities revealed no issues identified with the administration of the digoxin for the months of 11/11, 12/11, or 1/12. When the November review was completed, the resident was in the hospital. Per the consulting pharmacist on 1/26/12 at 3:15 p.m. he verified the pulse should have been checked prior to administering the digoxin. A SUGGESTED METHOD FOR CORRECTION: The administrator, along with the director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medications. Staff could be trained as necessary. The director of nursing could monitor medication monitoring on a regular basis. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received appropriate monitoring of medication for 1 of 10 resident (R91) in the sample reviewed for unnecessary medications. Findings include: An observation of medication administration at 12:25 p.m. on 1/25/12 revealed 91's pulse was not taken prior to the administration of Lanoxin	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 57 (Digoxin-a cardiac medication) as ordered by her physician. R91 had multiple diagnoses including atrial fibrillation. She had a physician's order for Lanoxin (digoxin) 0.25 mg by mouth every day and according to the facility's standing orders, which were also signed by her physician, staff were directed to not give this medication if R91's pulse was less than 55 beats per minute. A review of the medication administration records (MAR's) revealed there was no pulse documented for the months of November, 2011, December, 2011 and January, 2012 There was also no information on the MAR directing the facility staff to hold the digoxin for a pulse less than 55 or a prompt to take the pulse prior to administration. Interview with registered nurse (RN)-C at 8:15 a.m. on 1/26/12 revealed "I don't know why we don't take her pulse anymore. I'm thinking we used to but we don't do it anymore - but I don't know why. It's fallen off for a few residents where we used to do it and now we don't anymore." Clinical Manager (CM)-B at 8:30 a.m. on 1/26/12 verified the physician orders were accurate and the pulse should have been taken prior to administration of the digoxin. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the need for medication monitoring with the licensed staff including the State and federal regulations. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards. TIME PERIOD FOR CORRECTION: Twenty-one	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 58 (21) days.	21535		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services in a dignified manner related to visual limitations and the need for meal time assistance for 1 of 3 residents (R56) reviewed in the sample for dignity. Findings include: R56 did not receive meal time assistance in order to ensure a dignified experience when dining. R56 indicated during interview at 10:10 a.m. on 1/24/12, "they (the physician) called me legally blind." She further indicated that she has "gone blind since being here" and her vision had significantly deteriorated in the "last few months". She stated that one of her concerns was "They don't give me a lot of help at meals. I have a hard time feeding myself, getting the food on the fork and getting it to my mouth." R56 had multiple diagnoses including glaucoma and diabetes. During observation at 12:05 p.m. on 1/25/12, R56	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 59 wheeled into the dining room and with staff assistance was positioned at her table. R56 was provided hot water by staff and she independently placed her tea bag in the water. There was a bowl already on the table near her other glasses of milk and water. R56 pulled the bowl toward her and stated loudly enough to be easily heard "I don't know what we're eating." R56 then began to eat her lettuce salad, taking the first few bites easily. As there was less salad in the bowl, R56 used her opposite hand to feel inside the bowl for the lettuce and assist getting the lettuce onto the fork. As she pushed the lettuce onto the fork, she stated "I can't see it." R56 was able to feed herself the salad using both hands and feeling the food with her non-dominant hand. There was a scant amount of lettuce salad left in the bowl. At 12:30 p.m. R56 was provided a plate of food by dietary staff, without any verbal exchange or explanation of her food. R56 then asked her two table mates "What do we have to eat today? What's on my plate? Where is it?" R56 had pork steak, beets, mashed potatoes with gravy, carrots and a slice of bread with butter. R56 was told by table mates what was on her plate; however they were uncertain what the meat was. R56 began to eat her food without staff assistance, feeling her way across her plate with her left hand and a fork in her right hand. Once she was able to feel the food on her plate, she began to eat with a fork. The meat remained a large chunk of meat and had not been cut up in any way. R56 stabbed her fork into the meat in order to break off an approximately 3 cm x 3 cm piece of meat which she placed in her mouth. After that piece of meat she made no further attempts to eat the meat. R56 continued to eat with both hands - her left hand assisted to push food onto the fork, which was held by her right hand. As she attempted to	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 60 get her food onto the fork, her carrots and beets were pushed off of the plate onto the table. She would pick them up, place them back onto her plate and continue to eat, attempting to push them onto her fork with her free hand. At 12:50 p.m. R56 received her desert of peach cobbler. R56 again asked her table mates what she had to eat. Her table mates were uncertain what it was and as R56 poked her finger into the bowl of cobbler stated "I think it's something apple." R56 took one bite of cobbler getting only a small portion of the cobbler and whip cream with no peach as the peach kept slipping from the fork. R56 ate the one bite of cobbler and made no further attempts to eat. She had eaten approximately 50% of her meal and drank only her tea. The milk and water at the top of her plate remained untouched. There was a nursing assistant in the dining room throughout the entire meal; however he was feeding other residents at another table several tables away from R56. Multiple dietary staff were in and out of the dining room delivering food. Nursing staff members were in and out of the dining room, bringing residents, delivering medications and removing residents when they were done eating. Although there were multiple staff in the dining room, R56 received no clarifications on what she was eating or offers of assistance. When interviewed at 1:50 p.m. on 1/25/12 after the observed meal, R56 stated "I get by - the girls at my table are really good about telling me what we're eating. I like to be independent. They rush away so quickly, they don't seem to have time to answer my questions. I just really want to do things for myself as much as I can. I don't want everyone to know I can't see."	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING _____ B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 61 Nursing assistant (NA) C was present in the dining room throughout the entire meal. He was asked specifically about R56's need for meal time assistance and her visual limitations. At 1:30 p.m. on 1/25/12, NA-C stated "She always eats 75% or so of her meals. I ask her how she's doing and she always talks about - I'm losing my vision - I can't see that kind of thing. But she always eats - unless she's sick or something." Clinical Manager (CM) B was interviewed at 2:15 p.m. on 1/26/12 about R56's needs for meal time assistance and her visual limitations. She responded that dietary was looking into getting a dark plate in order to see her food better. She further indicated " I should make her an eye appointment to get her vision checked. I wasn't aware her sight was that bad. Her last ophthalmology appointment was 11/17/11 - but there was nothing specific about (R56's) visual ability. Part of what we talked about yesterday (in her scheduled care conference) was to have dietary explain food and use clock method when the food is provided to her." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are treated with dignity. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21805		