#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					ND TRANSMITTAL E SURVEY AGENCY		D: DGWP acility ID: 00038
I. MEDICARE/MEDICAID PROVIDER N           (L1)         245517           2.STATE VENDOR OR MEDICAID NO.         (L2)           206540100	Q.	3. NAME AND ADD (L3) OAKLAY (L4) 201 OAK (L5) MANKA	CLAWN AVE	H CAR	E CENTER (L6) 56001		<u>7(L8)</u> 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUB 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 1/9/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 12/31	DATE: (L35)
11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF         77         (L37)         16. STATE SURVEY AGENCY REMARK         See Attached Remarks	19 SNF (L39)	B. Not in Com Requirement ICF (L42)	nce With equirements e Based On: exceeptable POC pliance with Program ents and/or Applied W IID (L43)	/aivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Servic 7. Medical Direct	or
17. SURVEYOR SIGNATURE Sarah Grebenc, U	<b>^</b>		01/21/2014 D BY HCFA RE	(L19) GIONAI	18. STATE SURVEY AGENCY AP <u>Kate JohnsTon, Enfo</u> OFFICE OR SINGLE STAT	orcement Specialis	Date: t 03/19/2014 (L20)
19. DETERMINATION OF ELIGIBILITY         _X1. Facility is Eligible to Par        2. Facility is not Eligible	ζ.	20. COM	IPLIANCE WITH CI		21. 1. Statement of Financ	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	1513)
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension	DATE E SANCTIONS	24. LTC AGREEMEN ENDING DATE (L25) (L44)		26. TERMINATION ACTION:         VOLUNTARY       00         01-Merger, Closure         02-Dissatisfaction W/ Reimburseme         03-Risk of Involuntary Termination         04-Other Reason for Withdrawal	DINVOLUNT 05-Fail to Me nt 06-Fail to Me <u>OTHER</u>	L30) <u>ARY</u> eet Health/Safety eet Agreement Status Change
(L27) 28. TERMINATION DATE:	B. Rescind Sus	pension Date: . INTERMEDIARY/C	(L45)		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION ( 02/12/2014	OF APPROVAL DAT	E (L33)	DETERMINATION APPRO	VAL	

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: DGWP Facility ID: 00038

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2 Provider Number: 24-5517 Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective December 12, 2013, the facility is certified for 77 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245517

March 19, 2014

Ms. Stacy Kay Johnson, Administrator Oaklawn Health Care Center 201 Oaklawn Avenue Mankato, MN 56001 Dear Ms. Johnson:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective 12/12/2013 the above facility is certified for or recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Shalon

Kate Johnston, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring cc, Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

February 3, 2014

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

RE: Project Number S5517025

Dear Ms.. Johnson:

On December 10, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 31, 2013 that included an investigation of complaint number H5517013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 9, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 21, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 12, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 31, 2013, effective December 10, 2013 and therefore remedies outlined in our letter to you dated December 10, 2013, 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,

Santo Drebenc

Sarah Grebenc, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: 320-223-7365 Fax: 320-223-7348

Enclosure: Licensing and Certification File

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 245517	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/9/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
0/	AKLAWN 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) Da	te (Y4)	Item	(Y5	i) Date	(Y4)	Item		(Y5)	Date
ID Prefix Reg. # LSC	483.15(a)	Correc Comp 12/12/	leted	D Prefix Reg. # LSC	F0280 483.20(d)(3), 483.10(k)	Correction Completed 12/12/2013 (2)		ID Prefix Reg. # LSC	F0282 483.20(k)(3)(i	i)	Correction Completed 12/12/2013
ID Prefix Reg. # LSC	483.25(a)(2)	Correc Comp 12/12/	leted		F0314 483.25(c)	Correction Completed 12/12/2013		ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 12/12/2013
ID Prefix Reg. # LSC	483.30(a)	Correc Comp 12/12/	eted	D Prefix Reg. # LSC		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC	····	Correc Compl	eted	D Prefix Reg. # LSC		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			eted	D Prefix Reg. # LSC				ID Prefix Reg. # LSC			
Reviewed I State Agen Reviewed I CMS RO	icy	viewed By / 0562 viewed By	Dat C Dat	13/14	Signature of Su 16562 Signature of Su					Date: 2/? Date:	5]14
Followup	to Survey Comple 10/31/20				Check for any Unco Uncorrected Defi	orrected Defic ciencies (CM	siencie S-2567	es. Was a 7) Sent to	Summary of the Facility?	YES	NO

#### **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 245517	(Y2) Multiple Cons A. Building B. Wing	struction 01 - MAIN BUILDING 01	(Y3) Date of Revisit 1/21/2014
Name of Facility		Street Address, City, State, Zi	p Code
OAKLAWN HEALTH CARE CENTER		201 OAKLAWN AVENU MANKATO, MN 56001	JE

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) Da	ite	(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix		Corre Comp 11/20/	leted	ID Prefix		Correction Completed 11/20/2013	ID Prefix		Correction Completed
Reg. #	NFPA 101			Reg. #	NFPA 101		Reg. #		
LSC	K0050			LSC	K0052		LSC		-
		Corre	ction			Correction			Correction
		Comp				Completed			Completed
ID Prefix				ID Prefix			ID Prefix		_
Reg. #				Reg. #			Reg. #		
LSC				LSC	1		LSC		
		Corre	ction			Correction			Correction
		Comp				Completed			Completed
ID Prefix				ID Prefix			ID Prefix		_
Reg. #				Reg. #			Reg. #		_
LSC				LSC			LSC		-
		Correc	ction			Correction			Correction
		Comp	leted			Completed			Completed
ID Prefix				ID Prefix			ID Prefix		
Reg. #				Reg. #			Reg. #		_
LSC				LSC			LSC		-
		Correc	ction			Correction			Correction
		Comp	leted			Completed			Completed
ID Prefix			2.4	ID Prefix			ID Prefix		_
Reg. #				Reg. #			Reg. #		
LSC				LSC			LSC		-
Reviewed E	By 📝 Revie	ewed By		Date:	Signature of	Surveyor:	.1	Date:	
State Agen	cy /	0562		2-3-10	F 10562			Z-	3-14
Reviewed E CMS RO	By Revie	ewed By		Date:	Signature of	Surveyor:		Date:	
Followup t	o Survey Complete 11/5/2013					ncorrected Defic Deficiencies (CMS			NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.         (L1)       245517         2.STATE VENDOR OR MEDICAID NO.         (L2)       206540100         5. EFFECTIVE DATE CHANGE OF OWN         (L9)         6. DATE OF SURVEY       10/31         8. ACCREDITATION STATUS:         0 Unaccredited       1 TJC		3. NAME AND ADE (L3) OAKLAWI (L4) 201 OAKL (L5) MANKATO 7. PROVIDER/SUPI 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	N HEALTH ( AWN AVENU O, MN	CARE C JE	<u>02</u> 13 ptip 14 corf	(L6) (L7)	56001 22 CLIA	1. Initial 3. Termir 5. Validat 7. On-Site 8. Full Su FISCAL YE/	tion		
11. LTC PERIOD OF CERTIFICATION       From (a):       To (b):       12.Total Facility Beds       13.Total Certified Beds	77 (L18) 77 <sup>(L17)</sup>	10.THE FACILITY I A. In Complianc Program Rec Compliance 1. Ac X B. Not in Comp	IS CERTIFIED AS: ce With quirements Based On: cceptable POC		<u>And/Or</u> <u>2</u> . 3. 4.	Approved Techni 24 Hou 7-Day Life Sa	d Waivers Of The cal Personnel Ir RN RN (Rural SNF) afety Code	2 Following Requ 6. Sc 7. M 8. Pa			
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 77 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILI 1861 (e) (		ETS 61 (j) (1):	(	L15)		
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE	SHOW LTC CANCELI	LATION DATE):								
See Attached Remarks											
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURV	EY AGENCY AI	PPROVAL		Date:	
Mary Rogers, I	HFE NE II	(	01/13/2014	(L19)	Kate Jo	hns]	Ton, Enfo	rcement	Speciali	<u>st</u> 02/02/2	2014 (L20)
	PART II - TO I	BE COMPLETED	BY HCFA RE		OFFICE	OR SI	NGLE STAT	TE AGENCY			(120)
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>1. Facility is Eligible to Partice</li> <li>2. Facility is not Eligible</li> </ol>	cipate (L21)		PLIANCE WITH CI TS ACT:	VIL	21.	2. Ow	tement of Financi /nership/Control I th of the Above :			1513)	
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING I (L41) 27. ALTERNATIV	DATE	4. LTC AGREEMEN ENDING DATE (L25)		<u>VOLUNTA</u> 01-Merger, 02-Dissatist	L <u>RY</u> Closure faction V	DN ACTION: <u>00</u> W/ Reimbursemen ry Termination	nt	(L3 <u>INVOLUNTA</u> 05-Fail to Mee 06-Fail to Mee <u>OTHER</u>	<u>RY</u> t Health/Safety	
(L27)	A. Suspension o B. Rescind Susp	of Admissions:	(L44) (L45)		04-Other Re	eason for	Withdrawal		07-Provider St 00-Active	atus Change	
28. TERMINATION DATE:	29	INTERMEDIARY/CA	ARRIER NO.		30. REMA	RKS					
		03001									
	(L28)			(L31)							
31. RO RECEIPT OF CMS-1539	32	DETERMINATION O	DF APPROVAL DAT	ſΈ							
	(L32)			(L33)	DETERN	1INAT	TON APPRO	VAL			

ID: DGWP

Facility ID: 00038

DEPARTMENT OF HEALTH AND HU	MAN SERVICES	CENTERS FOR MEDICARE & ME	DICAID SERVICES
	MEDICARE/MEDICAID CERTIFICATION AND TRAN	ISMITTAL	ID: DGWP
	PART I - TO BE COMPLETED BY THE STATE SURVE	Y AGENCY	Facility ID: 00038
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS		

#### CCN-245517

At the time of the standard survey completed October 31, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. In addition, at the time of the November 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5517013 that was found to be substantiated with deficiencies cited at F353 and F241. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3612

December 10, 2013

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

RE: Project Number S5517025

Dear Ms. Johnson:

On November 5, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H55170136.

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. In addition, at the time of the November 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5517013 that was found to be substantiated with deficiencies cited at F353 and F241.

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

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

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

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

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

<u>Potential Consequences</u> - 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:

Sarah Grebenc, Unit Supervisor Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557

Phone: (320) 223-7365 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 December 10, 2013, 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 December 10, 2013 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 January 31, 2014 (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 May 1, 2014 (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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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 Oaklawn Health Care Center December 10, 2013 Page 6 Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5517s14.rtf

245517     P. WING     10/31/2013       AMLE OF PROVIDER OR SUPPLIER       SAKLAWN HEALTH CARE CENTER       SAKLAWN HEALTH CARE CENTER       SUMMARY STATEMENT OF DEFICIENCES       PRETX TAG     ESUMMARY STATEMENT OF DEFICIENCES       PRETX TAG     ESUMMARY STATEMENT OF DEFICIENCES     PRETX REGULATORY OR LSC IDENTIFYING INFORMATION)     PRETX REGULATORY OR LSC IDENTIFYING INFORMATION)     PRETX TAG       F 000     INITIAL COMMENTS     F 000       The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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       A complaint investigation had been completed at the time of the standard recertification survey. Investigations of compliant test 7101's had been completed and had been substantiated. Deficiencies had been issued as a result of the substantiated findings at F353 and F241.       F 241     483.15(a) DIGNITY AND RESPECT OF shanner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her inclividuality.       This REQUIREMENT is not met as evidenced by: . This REQUIREMENT is not met as evidenced by: . This REQUIREMENT is not met as evidenced by: . Subt fragity failed to ensure a signified dining experience for 7 of 19 residents (R6, R29, R19, R3, R85, R22 and R44) who ate in the South dining room. The facility also failed to so failing accent for faile to faile to failed to conspire		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Multif A. Building	PLE CONSTRUCTION G		TE SURVEY MPLETED
WARE OF PROVIDER OR SUPPLIER       STREET ADDRSS. CTV, STATE, ZP CODE         DAKLAWN HEALTH CARE CENTER       201 OAKLAWN AVENUE         DAKLAWN HEALTH CARE CENTER       MAINCATO, IN 56001         CMUED       SUMMARY STATEMENT OF DEFCIENCIES. REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX         PRETX TAG       SUMMARY STATEMENT OF DEFCIENCIES. REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX         F000       INITIAL COMMENTS       F000         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.       F000         Upon receipt of an acceptable POC an on-site regulations has been attained in accordance with your verification.       F000         A complaint investigation had been completed at the time of the standard recertification survey. Investigations of complaint H5617013 had been completed and had been substantiated. Deficiencies had been issued as a result of the substantiated findings at F353 and F241.       F241         A3. 16 (a) DIGNITY AND RESPECT OF SSEE       F241         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.       F241         Mit REQUIREMENT is not met as evidenced by:       Not the facility failed to ensure a dignifed by:       Not the facility faile to ensure a dignifed by:			245517	B. WING		10	/31/2013
Přeček TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRĚFIX TAG       (EACH DEFICIENCY)       (CACH DEFICIENCY)       COMĚĽÍM DEFICIENCY)         F 000       INITIAL COMMENTS       F 000	• • • •	and a second	NTER		201 OAKLAWN AVENUE		
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.Image: Complement of the complement	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI
<ul> <li>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.</li> <li>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.</li> <li>A completed and had been substantiated. Deficiencies had been issued as a result of the substantiated findings at F353 and F241.</li> <li>F 241 483.15(a) DIGNITY AND RESPECT OF</li> <li>INDIVIDUALITY</li> <li>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.</li> <li>This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 7 of 19 residents (R6, R29, R19, R29, R19, R29, R29, R29, R29, R29, R29, R29, R2</li></ul>	F 000	INITIAL COMMENT	S	F 000			
	F 241 SS=E	as your allegation of Department's accept bottom of the first particular be used as verification Upon receipt of an a revisit of your facility validate that substar regulations has been your verification. A complaint investigations of con- completed and had be substantiated finding 483.15(a) DIGNITY / INDIVIDUALITY The facility must pro- manner and in an en- enhances each resid full recognition of his This REQUIREMENT by: Based on observation review, the facility fai	f compliance upon the tance. Your signature at the age of the CMS-2567 form will on of compliance. Acceptable POC an on-site may be conducted to tital compliance with the n attained in accordance with ation had been completed at ard recertification survey. Inplaint H5517013 had been been substantiated. In issued as a result of the is at F353 and F241. AND RESPECT OF mote care for residents in a vironment that maintains or lent's dignity and respect in or her individuality. It is not met as evidenced on, interview and document led to ensure a dignified	F 241	a) 1. Hostess Pkogram 2. NAK assignents an 3. Diet Graff Koutine to helpt treay sex 9 NAK 4. Cross training Staff in dining Koom b.) 1. Dining Koom Supt par policy	dgusted adjusted wice instead to assist ies nuific n	600.2013 1012.013 F Trainin 112312.019 1012.013 1112.013+

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.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		TE SURVEY
•		245517	B. WING	G		
NAME OF	PROVIDER OR SUPPLIER				1 10	/31/2013
· · ·	VN HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE		-
				MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETI DATE
F 241	Continued From page	ge 1	F 241	C. DAII STADD Education a	h	
	requests.			Nr. prosch hone	· · 1	
	Findings include:			DK expectations Flu education		12/2013
	Ro was not provided	l with consistent and dignified the South dining room during		FILL EQUELOUTIN		115/20
	the noon meal on 10			2) DR requirements inc	uded	
				on OHL/NAR on-boa		
	R6's quarterly Minim	um Data Set (MDS)	•	Koutine	J	12 10
		/15/13, identified she had		KUUTIPU		12/2013
	severely impaired co					
	extensive assistance	for eating.		D. ) Audits per DA KO	utine	1/2014
	During a dining obse	rvation in the South dining				+ on spil
	room on 10/28/13, at	11:52 a.m. R6 was				J ,
		her meal. Nursing assistant				is stur
		and began to assist her with		Para 2 Dignity + Keypect of	s ena	unaua
	eating. NA-I was obs	served to place food on a			1	
	the food into her mou	en assisted her with placing uth. At 11:53 a.m., NA-I		A. 1) Juppont Survius T du	iking	
	stood up from the tab			meal times to ANSG til	me	11/2013
		5. NA-I communicated to		A. I) Support Survius A du meal times to ANSG til for resident cake new	da)	
1	other staff in the dinir	ig room that she was going			)	
	on her break. At 11:5	54 a.m., NA-C sat beside R6		2) Cross Inain of state		11/2013
	and began to provide assisted R6 by placin	eating assistance. NA-C g the food onto the spoon		enhance Can What ne.	sponse	final
		er mouth. R6 was observed			1	mining
		her mouth with cueing, on		B: 1) Charge Nurse Role		1/2014
	and left the dining roc	1:55 a.m. NA-C stood up		2) TALL Hole a lateral to A	1 ton	
		. R6 remained at the table	[	2) TMA Kule addeed to 1	TING	1/2n12
	ooking around, until			avuilability NSS for rustid	ut l'	1410
t	herapeutic recreation	director sat beside her and		ruels		
		sisting her to eat. At 11:59		C. ) QAPROGRAM FUITR	film	ĸ
2	a.m., the therapeutic	recreation director left R6,				
1	o assist another resid	d moved to a different table lent. R6 consumed about		2) HI trap concation to	ĸ	
		was wheeled out of the		expectation call yout	•	1 - ma
		imately 12:20 p.m., without		Kesponse	12	42013
	any further eating ass			<b>I</b>		
	R29, R19, R3, R85, R			D. Audits pur QA Kouti		120144

If continuation sheet Page 2 of 35 ongoing

		AND HUMAN SERVICES				•	FORM	): 12/10/2013 APPROVED
STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	TIPLE CONSTRU	JCTION	0		). 0938-0391 TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		NG				MPLETED
		245517	B. WING	· · · · · · · · · · · · · · · · · · ·			10	/31/2013
NAME OF	PROVIDER OR SUPPLIER				RESS, CITY, STATE, 2			
OAKLA	WN HEALTH CARE CE	NTER		201 OAKLAV MANKATO,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA0	ROVIDER'S PLAN OF CH CORRECTIVE AC S-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 241	provided with dignifi	ge 2 ed eating assistance in the luring the noon meal on	F 24	11				
	at risk for chewing/s required a soft diet v The care plan also r	ed 8/21/13, indicated she was wallowing problems and with nectar thickened liquids. noted, R29 had limited d extensive assistance for			• • •			
	required a pureed di liquids and was to be MDS dated 8/28/13,	ed 10/30/13, indicated she et, with pudding thickened e fed by staff. R19's quarterly identified her cognition was ind she was totally dependent			•			
	required a pureed di liquids. The care pla be fed by staff. Her	9/6/13, indicated she et and honey thickened in added that R3 needed to quarterly MDS dated 8/14/13, on was intact and she was staff for eating.						
	a fair appetite, but re encouragement to ea	d 9/20/13, indicated she had quired assistance and at. The care plan noted R85 ssistance to eat and drink.						
	had chewing problem edentulous (no teeth) R22 required a soft o	d 10/28/13, indicated she ns related to being ). The plan of care added, r pureed diet and staff provided, as needed, for						
		d 9/27/13, indicated he t with honey thick liquids.						
RM CMS-256	7(02-99) Previous Versions Of	osolete Event ID: DGWP11	Fa	cility ID: 00038		If continuation	sheet P	age 3 of 35

ORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 3 of 35

		& MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·		OMB NC	1 APPROVI ). 0938-03
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
	· · · ·	245517	B. WING		10	/31/2013
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	5	STREET ADDRESS, CITY, STATE, ZIP CO		
OAKI AV	NN HEALTH CARE CE	NTCO	2	201 OAKLAWN AVENUE	-	
UARLAV	WIN HEALTH CARE CE	NIER	R	MANKATO, MN 56001		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLÉTIC DATE
F 241	Continued From pa	ae 3	F 241			
		noted, R44 was able to feed	1 471			
		always do so. Staff were		•		ļ
	directed to encoura	ge him at meal times and				
	assist with eating as	s needed.		-		
	•	· · · · · · · · · · · · · · · · · · ·		-		
	During a dining obs	ervation on 10/30/13, at 12:46				
X I		and R85 were seated				
$\sim$		n the South dining room. R22				
		erent table, alone. R44 was				
		le, alone. R29, R19, R3,				
		vere observed seated quietly,				
		nt of them. NA-F was seated				
		85. During the observation,				
		te of food and then turned to				
		od. An unidentified staff			· .	
		ough the dining room. NA-F				
		ember, "Are you coming to				
		dentified staff member	*			
		ng on break," and proceeded				
		ning room. NA-F called to	Į			
		nication device (two-way				
		he was coming to help in the			2	
		lid not answer back. NA-F		· · · · ·		
		o stand up from her chair,				
		osite side of the table, stand vide R19 with a bite of her			[	
		ned to R3 and while still				
		drink of her thickened liquid.				
		valk to the table where R44				
		ed R44, "Can you wake up				
		ened, NA-F gave R44 a				
		NA-F returned to R85 and				
	R29, sat down betwe					
		a sip of liquid to R85. NA-F				
1	then turned to give R	29 a spoonful of food.				
1	Visibly frustrated, NA	-F used her communication				
		Illy need help in the South				
		52 p.m., dietary aide (DA)-A			<i>x</i>	
	sat down between R	19 and R3. DA-A indicated				

		HAND HUMAN SERVICES			FORM	): 12/10/20 / Approve ). 0938-039
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245517	B. WING		10	/31/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
OAKLAV	VN HEALTH CARE C	ENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORF	ECTION	(75)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 241	Continued From pa	age 4	F 241			
	she was a nursing working as a dietar fed anyone in a lon	assistant, but was currently y aide. She stated, "I haven't g time." DA-A stated she was				
	At 1:00 p.m., NA-A room. DA-A then le	aving," but would stay to help. came into the South dining eft the dining room and NA-A R19 and R3. NA-A and NA-F				
•	and R85, while encontinue eating. At	ites of food to R29, R19, R3 ouraging R22 and R44 to t 1:17 p.m., R22 started				
-	she was okay and v room. Most of R22 NA-F returned to th	ent to her side, asked R22 if wheeled her out of the dining 's food remained on her plate. e dining room and continued			• .	
	while still feeding re	red on 10/30/13, at 1:40 p.m., sidents in the South dining				
	least two aides in h NA-F indicated R22 be supervised while	ed, "There's supposed to be at ere. Today, we needed three." 2 and R44 were supposed to a eating and R29, R19, R3, attensive or total assistance to				-
	eat. NA-F stated, " staff, lack of training NA-A stated this wa indicated the NAs s	We're all tired of it. It's lack of g. It just keeps getting worse." Is a "typical" day. NA-F tarted assisting the first shift				
	added, "I've never u long to get through	noon meal at 11:30 a.m. She Inderstood why it takes so lunchWe [NA-F and NA-A] 30 p.m. and some aides are				
	done at 2:00 p.m before we leave so before we leave."	We have to toilet everyone it is sometimes 3:00 p.m.				
	services related to i	reported undignified care and ncontinent episodes, due to o their call light requests for				
		5 dated 10/17/13, identified				

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI T	IPLE CONSTRUCT	TION	(X3) DA	) <u>. 0938-03</u> TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN				MPLETED
	ų .	245517	B. WING		·	10	/31/2013
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRES	SS, CITY, STATE, ZIP COI	DE	
	/N HEALTH CARE CE	NTED		201 OAKLAWN AVENUE			
	NA HEALTH CARE OF	NIER		MANKATO, M	IN 56001		
(X4) ID		TEMENT OF DEFICIENCIES	ID		VIDER'S PLAN OF CORR		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		CORRECTIVE ACTION SI REFERENCED TO THE AF		COMPLETIC DATE
	· · · · · · · · · · · · · · · · · · ·				DEFICIENCY)		
_	······································	· · · · · · · · · · · · · · · · · · ·		•.			
F 241	Continued From pa		F 24	1	•		
	R14 with moderate	y impaired skills for daily					
		d required extensive					
		fers and toilet use. The MDS					
		lways continent of bladder					
	her urinary inconting	am was in place to manage					
		ment dated 7/11/13, noted,					
		riented and clearly makes					
		/n." The assessment					
		continent of urine. Staff were	e e e e e e e e e e e e e e e e e e e	-			
	to assist her and off	er toileting assistance upon					
		after meals, at bedtime and as					
		sment added, "[R14] uses					
ĺ		alert staff she needs the					
	toilet." The written plan of a	are reviewed 8/28/12					
		are reviewed 8/28/13, t risk for urinary incontinence					Í
		nobility and daily diuretic					
		e care plan noted R14 was					
		f bladder. Interventions					
		on rising in the morning,					
		als and activities, before					ļ
		ded. The care plan added,					
	"[R14] will call at nig						· .
	· · · · · · · · · · · · · · · · · · ·	on 10/31/13, at 9:12 a.m. R14					
		r call light to request f. She reported having to					
		staff to respond to her					
		ted she had been incontinent					
		onse to her call light request					
		ce. She added, "It felt					
	terrible."						
		S dated 10/1/13, revealed					•
		intact and required extensive			•		
		ng. The MDS identified R37					
		ontinent of bladder and a					
		s being used to manage her The Care Area Assessment					
	uonary incontinence	THAT THE ALES ACCORDING !		1			

ontinuation sheet Page 6 of 35 It

		AND HUMAN SERVICES				FOR	MAPPROVE 0. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCT	ION		TE SURVEY MPLETED
	· .	245517	B. WING	······	· · ·	10	/31/2013
NAME OF	PROVIDER OR SUPPLIER	L	1	STREET ADDRES	S, CITY, STATE, ZIP CODE		
				201 OAKLAWN	AVENUE		
OAKLAV	VN HEALTH CARE CE	NTER	14 - C	MANKATO, MN	N 56001	•••	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH C	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 241	Continued From pa	ge 6	F 2	41			
	incontinence and fu	nctional incontinence. The					
	CAA noted R37 rec	eived Detrol (a medication for					
	treatment of overac	tive bladder), was offered					
		er toileting schedule and used					
		est toileting assistance as					
	needed.				· · · · ·		
		ed 10/7/13, identified she had					
		incontinence related to					
		he care plan noted R37 to wash her hands, adjust her					
		berinea cares and transfer					
		pilet. Interventions revealed					
		rt staff when she needed to					
		interventions added, staff					
		eting upon arising, before and			•		
		me and as needed. In					
		R37 called for toileting					
	assistance, but was					1	
	incontinence while r						
		on 10/28/13, at 6:42 p.m. R37					
	reported she had ex	sult of untimely response to					
		tated, "They don't have					
		g. I've rang my buzzer and it's					
1	taken a half hour for	them to come I've had					
		t It's degrading." During a					
		on 10/31/13, at 8:50 a.m. R37					
		nts. She added that she		<i>,</i>			
		nence as a result of staff's					
		o her request for toileting					
		ximately three occasions in					
		again stated, "It's degrading."					
		10/30/13, at 6:10 a.m. NA-D episode of incontinence as a					
	direct result of staff's	s untimely response to her					
	call light. R27's bladder asses	sment dated 4/26/13,				· - 1	
		ble to verbalize her needs					
		assistance for raising and			,		
	67(02-99) Previous Versions (			Facility ID: 00038	If continua		

		AND HUMAN SERVICES				FORM	D: 12/10/2013 MAPPROVED D: 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA CO	TE SURVEY MPLETED
		245517	B. WING	;	1	10	/31/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN HEALTH CARE CE	NTER			201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D		PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 241	Continued From page	ae 7	F 2	241	1		
		for toileting. The assessment	1 2				
i	noted R27 was occa	asionally incontinent of					
	bladder, related to ir impairments.	mpaired mobility and cognitive					
		dated 8/1/13, identified R27					
	had a moderate cog	nitive impairment and			•.		
		assistance for transfers and					
		also noted R27 was nent of bladder and a toileting					
		e to manage her urinary					
	incontinence.						
		are dated 10/24/13, directed					
		eting assistance upon after meals and at bedtime.					
		to be offered toileting if she					
	appeared restless of	r if she requested. The plan			-		
		as alert and able to state					
		use the restroom. The plan					
		with limited to extensive					
	assistance of one sta	aff.					
		on 10/31/13, at 9:30 a.m. R27					
		e due to untimely responses ests for toileting assistance.					
		ost recent incident was			<b>b</b>		
		eek prior. R27 stated this					
		child." She added, the staff					
		vere times she was left to "sit he bathroom waiting for help					
	to get out."						
		intermittent print screen					
		ponse times from 10/23/13,					
	the following:	eview of this data revealed					·
		a.m. R14 waited 24 minutes					
	and 28 seconds for r	esponse to her call light.					
		a.m. R37 waited 29 minutes				· · ·	
		esponse to her call light. On n. R37 waited 28 minutes					ļ
	7(02-99) Previous Versions O			<b>r</b>	cjilty ID: 00038 If continuat	<u> </u>	

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION		ATE SURVEY DMPLETED
		245517	B. WING	_	· · · · · · · · · · · · · · · · · · ·	1	0/31/2013
NAME OF F	PROVIDER OR SUPPLIER		[	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	· · · · · · · · · · · · · · · · · · ·			2	201 OAKLAWN AVENUE		
OAKLAN	/N HEALTH CARE CE	NTER		N	MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	Continued From page	ae 8	· F2	41			
		response to her call light.	. –				
	On 10/23/13 at 6.11	B p.m. R27 waited 23 minutes					
	and nine seconds for	or response to her call light.					
	On 10/24/13, at 6:01	1 a.m. R27 waited 32 minutes					
	and 18 seconds for	response to her call light.					
	During interview on	10/31/13 at 9:41 a.m. director					
	of nursing (DON) re	ported that she began					
	working at the facilit	y several months prior, she					
	surveyed residents	and staff on what could be					
		ir experience at the facility.					
		most prominent response was verage in the dining rooms.					
	Since then she did	implement a process for		ĺ			
	management staff to	sign up to assist daily in the					
	dining rooms. She i	reported that her goal was to					
		ent staff covering each meal,					
	for at least one hour	, to help with feeding					
	residents. However	, she confirmed that not all					
	meals had been cor	sistently covered by this					
	process. Upon disc	ussion of the above noted					
		DON stated, "That should	v				
		The DON stated she was continence episodes related					
		response times. She					
	reported that she ex	pected episodes such as this					
		ought forward to the care					
		vance form completed so the					
	untimely response c	ould have been addressed.					
		she had not analyzed the					
		s to determine whether					
	patterns existed for	untimely response times.		ļ			
	She stated, "Our sta	If are not good at using the		ł			
	system now it's supp	posed to be used those					
	reports aren't very a	ccurate." The DON cited occasions when call lights				÷.,	
	several examples of	occasions when call lights off on, though staff had					
	already responded to	o the resident's concern. The					
	DON reported that s	he did use the call light logs					
	to investigate compl	aints or grievances related to			×		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DGWP11

Facility ID: 00038

If continuation sheet Page 9 of 35

		AND HUMAN SERVICES			FORM	12/10/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			E SURVEY PLETED
		245517	B. WING	e	10/3	31/2013
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	N HEALTH CARE C	ENTER	1 -	201 OAKLAWN AVENUE WANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241 F 280	483,20(d)(3), 483.1	y call light response. 10(k)(2) RIGHT TO	F 241 F 280			
SS=D	PARTICIPATE PLA The resident has the incompetent or othe incompetent or othe incapacitated under participate in plann changes in care are A comprehensive of within 7 days after comprehensive assist interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent p the resident, the re- legal representative	NNING CARE-REVISE CP erwise found to be er the laws of the State, to ing care and treatment or		<ul> <li>A. D. Care Plan will replece individualized residenced</li> <li>B. Individualized Care Plan Process</li> <li>C. Care plans vice be res @ initial, quentenly, plan of care changes ensure goals &amp; intervine maintain individu process.</li> </ul>	e inenced and to entippe	11/2013 +on sping 11/20134 on going 11/2013
	by: Based on observa review the facility f 1 of 3 residents (R repositioning scheo ulcer. Findings include: R19's care plan, da	NT is not met as evidenced ation, interview and document ailed to revise the care plan for 19) to identify an individualized dule for a stage one pressure ated 9/16/12, identified that asive assistance with bed		D. Audits per DA Noutine		1/2014 + on sping

		AND HUMAN SERVICES		,	FORM	: 12/10/2013 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		E SURVEY IPLETED
		245517	B. WING		10/	31/2013
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP C		
OAKLAV	VN HEALTH CARE CE	NTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280		lan for skin identified R19 had	F 280			
	right heel. The goal not acquire addition review date and the will show signs of he Interventions includ and nurse practition care. Report change to wear heel protect not slide resident/us	e ulcer to lateral aspect of was identified that R19 will al skin breakdown through pressure ulcer on right heel ealing by review date. ed: Follow MD/NP [physician er] orders regarding wound es in wound appearance. R19 or boots at all times. Lift, do se assistive devices to				
	[nursing assistants] nurse. Weekly skin Moisturize dry skin.	ear. Inspect skin daily, NAR to report any concerns to assessment by licensed staff. Bathe with mild soap, gently sessment/evaluation per				
	pressure ulcer (Intac redness of a localize prominence.) on her millimeter (mm) leng 10/29/13, the wound mm. The treatment	as identified with a stage one of skin with non-blanchable ed area usually over a bony right elbow that measured 1 gth by 1 mm width. On I was measured 4 mm x 4 plan identified R19 to have aff to turn and reposition urs.				
	10/30/13, R19 was a a.m. by nursing assi was wheeled out of room and placed in t wheelchair. At 6:44 a seated in her wheeld observed to be leani pressed against whe noted to have a posi	on of resident cares on assisted out of bed at 6:00 stant NA-I. At 6:20 a.m., R19 her room to the South day front of the television in her a.m., R19 was observed chair in dayroom and was ing to left side with left arm belchair/ armrest. R19 was tioning cushion on the left it was positioned too high to				

;

		AND HUMAN SERVICES				FOR	D: 12/10/2013 MAPPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		ATE SURVEY DMPLETED
		245517	B. WING		i	1	0/31/2013
NAME OF	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN HEALTH CARE CE	NTER			AKLAWN AVENUE KATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	support her from lea dayroom seated in left until 8:00 a.m. w South dining room. wheeled back to the	aning. R19 remained in the her wheelchair leaning to the when staff wheeled her into the At 9:25 a.m. R19 was South dayroom and left chair. R19 remained in her	F 2	80			
F 282 SS=D	on 10/30/13, at 1:15 repositioning sched toileting schedule w rising then before/at during rounds on nig be repositioned at le verified R19's care p schedule for staff to would have to corre	VICES BY QUALIFIED	F 21	82			
	must be provided by	ed or arranged by the facility v qualified persons in ch resident's written plan of		-			
1	by: Based on observati review, the facility fa plan of care was imp to an ambulation pro physical therapy (PT reviewed for rehabili failed to ensure to fo individualized reposi	T is not met as evidenced on, interview and document illed to ensure each resident's olemented as written, related ogram recommended by 7), for 1 of 4 residents (R106) tation. In addition, the facility illow the care plan for tioning needs to reduce the of pressure ulcers for 1 of 3		А. В.	1) Cake Plan+ Refide Sheets updated to in ambulation program 2) Support SURVICES the 1) above 5) Undervidualized Undervidualized	uudu ns .iuning	11/2013 11/2014

DGWP11

lf ç 12 of 35

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

PRINTED: 12/10/2013 FORM APPROVED

<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MR NO</u>	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		FÉ SURVEY MPLETED
	·	245517	B. WING			10	/31/2013
NAME OF	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN HEALTH CARE CE	NTER			1 OAKLAWN AVENUE ANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	residents (R9) who ulcers and had a his development. Findings include:	were reviewed for pressure story of pressure ulcer	F 2		C. Dambulation mill be documented in space cunical documentation	ity	12/2013
	ambulation program R106's written plan 10/28/13, identified mobility, related to g impaired cognition a her diagnoses. Goa ambulation for short	ollow R106's care plan for an of care, last reviewed on her with limited physical leneralized weakness, and activity intolerance due to als for R106 included distances. Interventions R106] to/from the bathroom			D. D. ambulation progra	yns	11.12,013 <del>1</del> 12/2,013
	to follow per PT Fo physical therapy. The nursing assistant updated 10/28/13, in bathroom and meals	assist, walker and wheelchair ollow direction provided by nt (NA) care sheet for R106 oted, Ambulate to/from the s with 1 [one] assist, walker,			munitored upon admi. quarterly, + z plan; Care changes per- noutine	strion, B. galid	12/2013 Y
	8:00 a.m. NA-I assis bathroom in her resi wheelchair was brout transfer on and off th	on 10/30/13, at approximately ted R106 to use the dent room. R106's ight into the bathroom for ne toilet. After using the			2) Audits pip QA Noutine		1/2014
	wheelchair to the No NA-I did not ambulat bathroom, nor to the a.m., R106 was obse going to walk her to NA-I replied that R10 then proceeded to se the North dining roor ambulate R106 to th During observation of NA-B assisted R106	breakfast meal. At 11:10 erved to ask NA-I if she was the dining room for lunch. 06 could go herself. R106 elf-propel her wheelchair to n for lunch. NA-I did not					

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DGWP11

Facility ID: 00038

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		AND HUMAN SERVICES			·			0938-03	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES							<u> </u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1					E SURVEY PLETED	
	<del>,</del>	245517	B. WING				10/:	31/2013	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP	CODE			
				20	01 OAKLAWN AVENUE				
OAKLAW	N HEALTH CARE CE			M	IANKATO, MN 56001			-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E E APPROPRI	BE ATE	(X5) COMPLETI DATE	ON
F 000			, <del>ن</del> ے	200					
F 282			F 4	282					
	into the bathroom for	or transfers. Her walker was							
	noted to be across	her resident room, next to her							
		not walk R106 to/from the			• *				
	bathroom.	on 10/20/12 of 2:05 nm							
	During an interview	on 10/30/13, at 2:05 p.m. N)-B verified R106 was on₋an							
	ambulation program	n where she was to be							
	ambulated to/from i	meals and to/from the							
	bathroom, Upon in	quiry as to how she monitored							
	that R106's ambula	tion program was							
	implemented, RN-E	3 reported that she did not							
	know, other than to	go by what she observed by			•				
	chance. She confir	med she did not do audits to							
	monitor implementa	ation of resident care plans. whether she routinely					[		
	observed R106 bei	ng ambulated to/from meals,							
	she confirmed that	she had not. Rather, she							
	added that she typi	cally saw R106 self-propel in							
	her wheelchair to m	eals. However, she insisted							
	that staff did walk h	er to/from the bathroom. After							
	discussion of the at	pove noted observations,							
	RN-B stated, "They	should be walking with her."							
	RN-B verified there	was no formal documentation							
	was being impleme	r R106's ambulation program							
	During an interview	on 10/30/13, at 2:10 p.m.							
	NA-B verified that to	o her knowledge, there was no							
	ambulation program	n for R106. NA-B added, the							
	activities program v	valked with R106 at times, but							
	aside from walking	with activities, she was not			·				
	aware of needing to	o walk R106 to/from meals and							
	to/from the bathroo	m.							
	During an Interview	r on 10/30/13, at 2:12 p.m. R106 did not have an							
	ambulation program	n. She added, to her							
	knowledge R106 o	nly walked to/from some							ĺ
	activities.								
	During an observat	ion on 10/30/13, at 2:39 p.m.							
	NA-I was noted to u	use the wheelchair to transport							
ORM CMS-25	i67(02-99) Previous Versions		1	Faci	ility ID: 00038 If	continuation	sheet P	age 14 of	35

	ND HUMAN SERVICES				ORM APPROVED B NO. 0938-0391
CENTERS FOR MEDICARE 8					(3) DATE SURVEY
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED
	245517	B. WING			10/31/2013
NAME OF PROVIDER OR SUPPLIER		SI	REET ADDRESS, CITY, STATE, ZIP	CODE	·
OAKLAWN HEALTH CARE CEN	TER		1 OAKLAWN AVENUE		
		F	ANKATO, MN 56001	2005071011	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DIDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	
toileting. NA-I did not bathroom. During an interview o activity director (AD) i routinely ambulate the program. She indicat staff walked R106 at During an interview o verified she had record program for R106, to to/from the bathroom. R106 having been an by the facility's activity replied it was not. Sh expectation was that ambulated to/from me bathroom to maintain movement, strength a During an interview o director of nursing (Di expectation that facility resident's plan of care NAs were expected to that were not complet explanation of why the The facility's Using the 8/06, revealed NAs w to the RN when any c or an expected outcom	her resident bathroom for t ambulate R106 to/from the in 10/31/13, at 8:37 a.m. reported that R106 did rough the facility's activity ted that the activity program least three times weekly. in 10/31/13, at 8:56 a.m. PT immended an ambulation walk to/from meals and . Upon inquiry as to whether inbulated three times weekly y program was sufficient, PT is added that her R106 was routinely eals and to/from the or improve her joint and stamina. in 10/31/13, at 9:41 a.m. ON) verified it was her ty staff implemented each is a written. She added or report any care plan tasks ted to the RN, with an is tasks were not completed. is Care Plan policy revised ere responsible for reporting are plan goals were not met me not achieved.	<	ile @ Osing 7. Policy fre we followy tre Statt awate	+ Nolic	<u>y ?</u>
R9 was admitted to th a tissue profusion tes 7/3/13, which identifie	e for R9 he facility on 7/2/13, and had t conducted by the facility on d she had a stage one skin with non-blanchable	· · · · · · · · · · · · · · · · · · ·	(NARTNURS) Need-to make the		
FORM CMS-2567(02-99) Previous Versions Ob	esolete Event ID: DGWP1	1	esponsible for	a fall and in Round & start from work of some of a	5

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		AND HUMAN SERVICES				~		
<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES	1			0	1	. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1					TE SURVEY MPLETED
		245517	B. WING			· · ·	: 10/	31/2013
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
OAKLAV	VN HEALTH CARE CE	NTER			01 OAKLAWN AVENUE IANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 282	redness of a localiz prominence.) on he identified R9 was al hour and lying for tw R9's care plan date repositioning sched after meals, bedtime During observation at 6:20 a.m. nursing observed to enter R bed. At 6:40 a.m., a cares R9 was whee room. R9 was obset the facility in her wh chair with her feet. A observed to wheel h room and eat break completed her brea of the dining room. A her wheelchair lock aviary in the North of wheelchair without h a.m. (four hours and opportunity to repose On 10/30/13, at 11:0 and verified R9 had toileted since she w 6:20 a.m. NA-B stat she needed to toilet and repositioned at	ed area usually over a bony r coccyx. The document ole to tolerate sitting for one vo hours without redness. d 8/13/13, identified her on a ule as upon rising, before/ e, and during rounds on night. of morning cares on 10/30/13, g assistant (NA)-A was 9's room and assist her out of fter completion of morning led out into the North day erved to wheel herself around eelchair by propelling the At 8:00 a.m., R9 was herself to the South dining fast. At 8:30 a.m., R9 kfast and wheeled herself out At 9:00 a.m., R9 remained in ing at the birds in the bird layroom. R9 remained in her being repositioned until 11:15 d 55 minutes) from the last ition. 03 a.m. NA-B was interviewed not been repositioned or as assisted up for the day at ed R9 informed staff when . NA-B stated R9 was toileted the same time.	F 2	282				
	(RN)-B was interview improved in her ove R9 was admitted shi	5 a.m. registered nurse wed. RN-B stated R9 had rall health. RN-B stated when e was at high risk for lopment but she was now at a						
ORM CMS-25	37(02-99) Previous Versions (	Obsolete Event ID: DGWP1	1	Facil	ity ID: 00038  f (	continuation	sheet P	age 16 of 35

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE 5 A. BUILDING					
		245517	B. WING			10/	31/2013	
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	/N HEALTH CARE CE	NITER			01 OAKLAWN AVENUE			
UARLAN	IN HEALTH CARE OF			M	IANKATO, MN 56001		····	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	developed the curre	n asked how the facility ant repositioning schedule that	F 2	282				
	could potentially ha hour intervals RN-B toileting plan was for every two hours. RN was too long for a n ulcer development t	ve a resident repositioned at 5 stated the concept of the residents to be repositioned V-B verified over 2 1/2 hours esident at risk for pressure to wait to be repositioned.	F3	211				
F 311 SS=D	IMPROVE/MAINTA A resident is given t services to maintair	TMENT/SERVICES TO IN ADLS he appropriate treatment and or improve his or her abilities uph (a)(1) of this section.		, , , ,	A. ) Refident mill be as to walk pen Cake Plan	keel 4	11/2013	
-	by: Based on observat review, the facility fa programs to mainta abilities, for 1 of 4 re rehabilitation. Findings include: R106's quarterly Mi 10/16/13, revealed assistance for trans also noted R106 re walking in her room the MDS indicated walker and wheelch The care plan, last identified R106 with related to generaliz cognition and activit diagnoses. Goals f for short distances.	NT is not met as evidenced ion, interview and document ailed to implement ambulation in or improve ambulation esidents (R106) reviewed for nimum Data Set (MDS) dated R106 required extensive ifers and toilet use. The MDS quired limited assistance for and on the unit. In addition, R106 required the use of a hair for mobility. reviewed on 10/28/13, limited physical mobility, ed weakness, impaired ty intolerance due to her or R106 included ambulation Interventions directed, /from the bathroom and meals			direction a) Staff Educated to propan i daily huddle Schanges B. D. Nebidents nucl Ju ambulation program be addressed on add guarterey, & plan of C changes (PS as rest und indicates rece C. D. Staff Education Flu Education a) Support Schurchs Education a) Support Schurchs Education	ambull on well missin dunt essisy	u bn, 12/2013 12/2013 12/2013 1/2014	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DGWP11

Facility ID: 00038

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CONSTRUCTION		X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER:		IG	CO	COMPLETED		
245517		B. WING _		10	10/31/2013			
NAME OF	PROVIDER OR SUPPLIE	]		STREET ADDRESS, CITY, STATE, ZIP CODE				
OAKLAV		CENTER	•	201 OAKLAWN AVENUE MANKATO, MN 56001				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)		
PRÉFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETIC		
F 311	Continued From	bage 17	F 31	1				
		alker and wheelchair to follow			. I .			
	per PT [physical t provided by physi	herapy] Follow direction		D. D. Audits per QA KU 2) Monstoning on adm -guankary, N pra Jacility Koutine.	unne	2014 4		
		stant (NA) care sheet for R106				ongoin		
	updated 10/28/13	, noted, Ambulate to/from the		2) Monitoring on adm	ushon	-		
	bathroom and me and wheelchair to	als with 1 [one] assist, walker,		-quankaly, N pRA	per	la la mi 2		
		ation on 10/30/13, at		Racility Kouping		12/2013		
	approximately 8:0	0 a.m. NA-I assisted R106 to		protect protective.		abnspi		
	use the bathroom	in her resident room. R106's						
		rought into the bathroom for If the toilet. After using the						
		vas observed to self-propel her						
		North dining room for breakfast.	-					
		late R106 to/from the						
	bathroom, nor to t	the breakfast meal. At 11:10 bserved to ask NA-I if she was				•		
		to the dining room for lunch.						
		R106 could go herself. R106						
	then proceeded to	self-propel her wheelchair to						
		pom for lunch. NA-I did not				1		
	ambulate R106 to	ation on 10/30/13, at 1:55 p.m.						
		06 to utilize the bathroom in her						
	resident room. R	106's wheelchair was brought				l		
		for transfers. Her walker was						
	noted to be across	s her resident room, next to her I not walk R106 to/from the						
	bathroom.					:. ·		
		w on 10/30/13, at 2:05 p.m.				l		
		RN)-B verified R106 was on an			,			
		m where she was to be meals and to/from the	~					
		inquiry as to how she monitored				,   ,		
		ation program was						
	implemented, RN-	-B reported that she did not						
	know, other than t	o go by what she observed by						
	chance. She cont	firmed she did not do audits to	· · ·					

		AND HUMAN SERVICES					APPROVED 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		245517	B. WING _		<u> </u>	10/:	31/2013		
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, ST	ATE, ZIP CODE			7	
				201 OAKLAWN AVENUE					
OAKLAW	N HEALTH CARE CE	NIER		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	(EACH CORRECTIV CROSS-REFERENCE		BE	(X5) COMPLETION DATE		
	observed R106 beir she confirmed that s added that she typic her wheelchair to m that staff did walk he discussion of the ab RN-B stated, "They RN-B verified there to evidence whether was being implemen During an interview NA-B verified that to ambulation program activities program w aside from walking v aware of needing to to/from the bathroor During an interview NA-I reported that R ambulation program knowledge, R106 or activities. During observation of was noted to use the R106 into and out of toileting. NA-I did no bathroom. During an interview	whether she routinely ng ambulated to/from meals, she had not. Rather, she cally saw R106 self-propel in eals. However, she insisted er to/from the bathroom. After nove noted observations, should be walking with her." was no formal documentation r R106's ambulation program nted. on 10/30/13, at 2:10 p.m. her knowledge, there was no for R106. NA-B added, the ralked with R106 at times, but with activities, she was not walk R106 to/from meals and	F 3 <sup>-</sup>		CIENCY)				
	routinely ambulate the program. She indica staff walked R106 and During an interview verified she had reco program for R106, to to/from the bathroon R106 having been a	hrough the facility's activity ated that the activity program t least three times weekly. on 10/31/13, at 8:56 a.m. PT ommended an ambulation o walk to/from meals and n. Upon inquiry as to whether mbulated three times weekly ty program was sufficient, PT							
OPM CMR 250	7/02-00) Provinue Versions (	bsolete Event ID: DGWP11	1 F	acility ID: 00038	If continuation	sheet D	ne 19 of 35		

		& MEDICAID SERVICES		0	<u>MB NO. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245517	B. WING		10/31/2013
	OVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE VIANKATO, MN 56001	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 314 SS=D F 314 F 315 F 314 F 315 F 314 F 315 F	ambulated to/from r pathroom to maintai novement, strength During an interview lirector of nursing (i expectation that fac umbulation program esident's written pla vere expected to re vere not completed xplanation of why to the facility's Goals a cervices policy revise the facility of the facility who enters the facility who enters the facility who enters the facility who enters the facility ressure sores rece ervices to promote revent new sores factors his REQUIREMEN y: Based on observative wiew the facility fai	She added that her it R106 was routinely neals and to/from the in or improve her joint and stamina. on 10/31/13, at 9:41 a.m. DON) verified it was her ility staff implemented is as indicated by each an of care. She added NAs port any care plan tasks that to the RN, with an he tasks were not completed. and Objectives, Restorative sed 12/07, directed, and objectives are developed d are outlined in his/her plan erapy services. ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ty without pressure sores essure sores unless the ondition demonstrates that ole; and a resident having ives necessary treatment and healing, prevent infection and	F 311	<ul> <li>A. D. Fisson Tourance + Br assassments</li> <li>D) NSB Wraft training Flu Education</li> <li>B. D. Tisson Tourance Assess as assigned</li> <li>C. D. Assessments assigned</li> <li>C. D. Assessments assigned</li> <li>D. Madits per QA Kour</li> </ul>	"12013 Complete 12/2013 1/2014 SSMANT II 12013 as 11/2013 ned 11/2013
. re	educe the risk of de	evelopment of pressure ulcers		D. 1) MIDURS PUR QALOU	TINE 112014

		AND HUMAN SERVICES			· · · · · · · · · · · · · · · · · · ·	FC OMB	TED: 12/10/2013 DRM APPROVED NO: 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL A. BUILC		ECONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED		
		245517	B. WING				10/31/2013	
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, Z	IP CODE		
OAKLAW	N HEALTH CARE C	INTER			ANKATO, MN 56001			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETION DATE	
F 314	for 2 of 3 residents	(R9 and R19) who were ure ulcers and had a history of	F	314				
	repositioning sched							
	a tissue profusion of 7/3/13, which ident pressure ulcer (Inta redness of a localiz prominence.) on he identified R9 was a	b the facility on 7/2/13, and had test conducted by the facility on ified she had a stage one act skin with non-blanchable zed area usually over a bony er coccyx. The document able to tolerate sitting for one wo hours without redness.			· · ·			
	her at risk for skin mobility, incontiner was identified to ne staff with all mobilit identified R9 was a	ent dated 10/9/13, identified breakdown related to impaired nee, and poor appetite. She bed extensive assist of one ty needs. The assessment assisted to reposition upon meals, bedtime, and night						
	repositioning sche	ed 8/13/13, identified her on a dule as upon rising, before/ ne, and during rounds on night.						
	Wound Note to ha	is identified on a Weekly ve developed a stage 2 her right buttocks measuring m) long by 0.5 cm wide.						
	at 6:20 a.m. nursin	n of morning cares on 10/30/13, g assistant (NA)-A was R9's room and assist her out of s Obsolete Event ID: DGWF		Fac	ility ID: 00038	If continuation si	neet Page 21 of 35	

		AND HUMAN SERVICES						APPR 0938	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 10/31/2013			
									NAME OF PROVIDER OR SUPPLIER
				201	1 OAKLAWN AVENUE				
OAKLAW	/N HEALTH CARE CE	NIER		MA	ANKATO, MN 56001				
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	E	(X COMPL DA	5) .ETION .TE
F 314	Continued From pa	ne 21	E3	314					
1 514		after completion of morning							
	peu. Al 0,40 a.m., a	eled out into the North day							
	room. R9 was obse	erved to wheel herself around							
	the facility in her wh	neelchair by propelling the							
	chair with her feet.	At 8:00 a.m., R9 was							
	observed to wheel	herself to the South dining	~						
	room and eat break	fast. At 8:30 a.m., R9							
	completed her brea	kfast and wheeled herself out At 9:00 a.m., R9 remained in							
	or the dining room.	ing at the birds in the bird							
	aviary in the North	dayroom. R9 remained in her							
	wheelchair without	being repositioned until 11:15							
	a.m. (four hours and	d 55 minutes) from the last							
	opportunity to repos	sition.			• .				
	and verified R9 had toileted since she w 6:20 a.m. NA-B sta	03 a.m. NA-B was interviewed I not been repositioned or vas assisted up for the day at ted R9 informed staff when t. NA-B stated R9 was toileted the same time.		-					
	On 10/31/13 at 7.5	5 a.m. registered nurse							
	(RN)-B was intervie	wed. RN-B stated R9 had							
	improved in her over	erall health. RN-B stated when							
	R9 was admitted sh	he was at high risk for	ļ						
	pressure ulcer deve	elopment but she was now at a							
	developed the curre	ent repositioning schedule that							
	could potentially ha	ve a resident repositioned at 5							
	hour intervals RN-E	stated the concept of the							
	toileting plan was fo	or residents to be repositioned							
	every two hours. RI	N-B verified over 2 1/2 hours							
	was too long for a r	esident at risk for pressure							
	When asked about	reassessment of residents							
	who developed pre	ssure ulcers the RN stated							
	she was not aware	that R9 had developed a							
	pressure ulcer 9/10	/13, and stated there should						<u> </u>	
DRM CMS-25	R9 was admitted sh pressure ulcer developed the curre could potentially ha hour intervals RN-E toileting plan was for every two hours. RI was too long for a r ulcer development When asked about who developed pre- she was not aware	he was at high risk for elopment but she was now at a en asked how the facility ent repositioning schedule that ve a resident repositioned at 5 8 stated the concept of the or residents to be repositioned N-B verified over 2 1/2 hours esident at risk for pressure to wait to be repositioned. reassessment of residents ssure ulcers the RN stated that R9 had developed a /13, and stated there should	11	Facili	ty ID: 00038  f contin	uation s	heet I	Page 2	2

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· / · · ·	PLE CONSTRUCTION		TE SURVEY		
		245517	B. WING		10	10/31/2013		
NAME OF I	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE				
OAKLAV	N HEALTH CARE CE	ENTER		201 OAKLAWN AVENUE MANKATO, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 314	Continued From pa have been a reasse were changing risk	age 22 essment to identify if there factors for development.	F 314	4				
	The facility failed to repositioning scheo	identify guidelines for a lule for R19.		·	y			
	moderate risk for sl scale assessment. repositioned throug	assessment identified her at kin breakdown per Braden R19 was to be turned and hout the day with naps and outine rounds on nights.				-		
	of pressure ulcers. identified R19 as de	rterly MDS identified her free The assessment further ependent on staff for bed n, dressing, toileting, and						
	pressure ulcer (Inta redness of a localiz prominence.) on he millimeter (mm) len 10/29/13, the woun mm. The treatmen	was identified with a stage one act skin with non-blanchable red area usually over a bony er right elbow that measured 1 ogth by 1 mm width. On d was measured 4 mm x 4 t plan identified R19 to have taff to turn and reposition urs.						
	R19 required exten mobility. The care p unstagable pressur right heel. The goal not acquire addition review date and the will show signs of h Interventions include	ted 09/16/12, identified that sive assistance with bed blan for skin identified R19 had e ulcer to lateral aspect of was identified that R19 will hal skin breakdown through e pressure ulcer on right heel ealing by review date. led: Follow MD/NP [physician her] orders regarding wound						

		AND HUMAN SERVICES				-	FORM	: 12/10/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245517	B. WING				10/	31/2013
NAME OF F	PROVIDER OR SUPPLIER		Liame		TREET ADDRESS, CITY, STATE,	ZIP CODE		
OAKLAW	N HEALTH CARE CE	NTER		1	01 OAKLAWN AVENUE IANKATO, MN 56001			,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN 01 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	) BE	(X5) COMPLETION DATE
F 314	to wear heel protec not slide resident/us decrease friction/sh [nursing assistants] nurse. Weekly skin Moisturize dry skin.	ge 23 es in wound appearance. R19 tor boots at all times. Lift, do se assistive devices to lear. Inspect skin daily, NAR to report any concerns to assessment by licensed staff. Bathe with mild soap, gently issessment/evaluation per	F	314				
	10/30/13, R19 was a.m. by nursing ass was wheeled out of room and placed in wheelchair. At 6:44 seated in her wheel observed to be lear pressed against wh noted to have a pos side of her chair bur support her from lead dayroom seated in left until 8:00 a.m. w South dining room. wheeled back to the	ion of resident cares on assisted out of bed at 6:00 sistant NA-I. At 6:20 a.m., R19 her room to the South day front of the television in her a.m., R19 was observed Ichair in dayroom and was hing to left side with left arm eelchair/ armrest. R19 was sitioning cushion on the left t it was positioned too high to aning. R19 remained in the her wheelchair leaning to the when staff wheeled her into the At 9:25 a.m. R19 was e South dayroom and left Ichair. R19 remained in her :00 a.m.						
	stated R19 was toll asked when last toll NAR worksheet tha toileted at 9:45 a.m. identify who had toi During an interview	with RN-A on 10/30/13 1:15	-					
	to toileting and repo	be had visited with staff related positioning R19. She stated staff	4.5		ility ID: 00038			Page 24 of 35

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 12/10/2013 MAPPROVED 0. 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		245517	B. WING		1	0/31/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
OAKLAV	VN HEALTH CARE CE	NTER		201 OAKLAWN AVENUE MANKATO, MN 56001	. ' 	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE	(X5) COMPLETION DATE
	Continued From par informed her they d but simply repositio the wheelchair. RN- repositioning sched toileting schedule w rising then before/ar rounds on night. RN repositioned at leas R19 care plan lacke for staff to follow an to correct the care p 483.25(d) NO CATH RESTORE BLADDI Based on the reside assessment, the fac resident who enters indwelling catheter i resident's clinical co catheterization was who is incontinent of treatment and service infections and to res function as possible This REQUIREMEN by: Based on observati review, the facility fac care and services to function for 2 of 3 re reviewed for incontin	ge 24 id not toilet R19 at 9:45 a.m. ned her by sliding her up in A stated R19 had a ule that correlated with her hich was to toilet R19 upon fter, hour of sleep and during I-A stated R19 should be t every 2 hours. RN-A verified any repositioning schedule d she stated she would have blan. IETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a the facility without an s not catheterized unless the indition demonstrates that necessary; and a resident f bladder receives appropriate cost to prevent urinary tract store as much normal bladder IT is not met as evidenced on, interview and document illed to provide the necessary maintain or enhance bladder isidents (R9 and R19)	F 3	15 A Individua completed by 7 B. i) Individu plan 1) Stapp Edu Individu 3) Care Sheet	ulized) Pox gaility PA alized) Care u cation to CP developm to identify site ting plan	11/2013
	Findings include: R9 was not offered ther individualized net	o use the toilet according to	•	D. DAudits per ( 2) Continued	DA Koutine	1/2014
ORM CMS-25	67(02-99) Previous Versions	Dbsolete Event ID: DGWP1	1	Facility ID: 00038	If continuation sheet	

		AND HUMAN SERVICES				FORM	): 12/10/2013 /I APPROVED ), 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA CO	TE SURVEY MPLETED
		245517	B. WING				/31/2013
NAME OF I	PROVIDER OR SUPPLIER	· · · ·	-		STREET ADDRESS, CITY, STATE	, ZIP CODE	
OAKLAW	VN HEALTH CARE CE	NTER			201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 25	F	315			
	7/8/13, identified R functional incontine mobility. The asses and oriented to self	adder assessment conducted 9 was incontinent of urine, with ence, related to impaired ssment noted she was alert and family. R9 was unable to ng needs so staff were to s.					
	assessment dated occasionally incont The MDS also note	num Data Set (MDS) 10/21/13, identified she was inent with a toileting schedule. Id she required extensive ctivities of daily living (ADLs).					
	altered elimination diuretic use, and im identified to be on a	ed 8/13/13, identified her with related to impaired mobility, apaired cognition. R9 was a toileting schedule of upon meals, bedtime and during					
	at 6:20 a.m. nursing observed to enter F bed. At 6:40 a.m., cares, R9 was whe room. R9 was obs the facility in her wh chair with her feet. observed to wheel room and eat break completed her break of the dining room. her wheelchair look aviary in the North wheelchair without	of morning cares on 10/30/13, g assistant (NA)-A was R9's room and assist her out of after completion of morning eled out into the North day erved to wheel herself around neelchair by propelling the At 8:00 a.m., R9 was herself to the South dining cfast. At 8:30 a.m., R9 kfast and wheeled herself out At 9:00 a.m., R9 remained in king at the birds in the bird dayroom. R9 remained in her being toileted until 11:15 a.m. d for a period of four hours					
ORM CMS-28	67(02-99) Previous Versions	Obsolete Event ID: DGWP	11	Fa	acility ID: 00038	If continuation sheet	Page 26 of 35

		AND HUMAN SERVICES						FORM	: 12/10/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			CONSTRUCTION	1		(X3) DAT CON	E SURVEY IPLETED
		245517	B, WING _					10/	31/2013
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS,		, ZIP CODE		
OAKLAW	IN HEALTH CARE CE	INTER			OAKLAWN AV NKATO, MN		-		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(FACH CC	RRECTIVEA	OF CORRECTION COTION SHOUL O THE APPROI	d be	(X5) COMPLETION DATE
F 315	Continued From pa	age 26	F 31	15					
	(NA)-B was intervie been toileted. NA-B when she needed to occasionally incont she was unaware of On 10/31/13, at 7:5 (RN)-B was intervie improved in her over R9 was admitted, so of urine, but now w When asked how to current toileting sch allow a five hour intervie stated that the cond for residents (include two hours. RN-B ver	03 a.m. nursing assistant awed and verified R9 had not 3 stated that R9 informed staff to toilet. NA-B stated R9 was inent of urine. NA-B stated of a toileting schedule for R9. 55 a.m. registered nurse awed. RN-B stated R9 had erall health. RN-B stated, when she was frequently incontinent as occasionally incontinent he facility developed the nedule, which could potentially terval between toileting, RN-B cept of the toileting plan was ding R9) to be toileted every erified that a period of over two as too long for a resident to ing.							
	her individualized r	•		3					
. · · · · ·	dated 5/22/13, ider	are Area Assessment (CAA) atified R19 was incontinent of ors that included: restricted icy of urine.							
	required extensive her plan for inconti toilet upon rising, b	ted 9/10/12, identified she assistance with toileting and nence maintenance was to efore/after meals and activities during routine night rounds.			•				
	R19 was assisted (	of resident cares on 10/30/13, out of bed at 6:00 a.m. by NA-I. was wheeled to the South day S Obsolete Event ID: DGWP	44	Eanilib	ID: 00038		If continue	tion sheet	Page 27 of 35

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		AND HUMAN SERVICES				FORM	: 12/10/2013 APPROVED	
STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		PLE CONSTRUCTION	(X3) DAT	0. 0938-0391 TE SURVEY MPLETED	
		245517	B. WING	I		10/31/2013		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
OAKLAV	VN HEALTH CARE CE	NTER			201 OAKLAWN AVENUE MANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 315	room and placed in wheelchair. At 6:44 seated in her wheel remained in the day staff wheeled her in 9:25 a.m., R19 was dayroom and left se remained in her who 11:10 a.m., NA-A w	ge 27 front of the television in her a.m., R19 was observed chair in the dayroom. R19 room until 8:00 a.m., when to the South dining room. At wheeled back to the South wheeled back to the South ated in her wheelchair. R19 eel chair until 11:00 a.m. At as interviewed and stated she a.m. (five hours from last	F3	315				
	toileting). NA-A veri urine when toileted During interview wit p.m., she verified sh related to toileting R toileting schedule w rising, then before/a bedtime and during stated R19 should h every two hours.	fied R19 was incontinent of at 11:00 a.m. h RN-A on 10/30/13, at 1:15 he had visited with staff (19. RN-A stated R19 had a hich was to toilet her upon ifter meals and activities, at rounds overnight. RN-A have been toileted at least						
F 353 SS=E	PER CARE PLANS The facility must har provide nursing and maintain the highes and psychosocial w determined by resid individual plans of c The facility must pro- numbers of each of personnel on a 24-h	ve sufficient nursing staff to related services to attain or t practicable physical, mental, ell-being of each resident, as ent assessments and are. wide services by sufficient the following types of your basis to provide nursing	F 3	353	A. D Hospiss Propan de 2) NAX assignments a 3) Cross Training of D. 4) Dietary Koutine Ch. 5) Addition TMA the B. D above 2) DK supervision per Policy	n the ted adjusted topg anged upam n Jacule	10 2013 11 2013 To Be Conylete 12014 12 2013 10+11/2013	
	care plans:	In accordance with resident d under paragraph (c) of this				-	Page 28 of 35	

		HAND HUMAN SERVICES E & MEDICAID SERVICES		F	TED: 12/10/201 ORM APPROVEI NO: 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	LE CONSTRUCTION (X:	) DATE SURVEY COMPLETED
		245517	B. WING		10/31/2013
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
OAKLAN	WN HEALTH CARE C	ENTER		201 OAKLAWN AVENUE MANKATO, MN 56001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 353	section, licensed n personnel. Except when waive section, the facility	age 28 urses and other nursing ed under paragraph (c) of this must designate a licensed a charge nurse on each tour of	F 353	C. DAN Graff education T Flu e ducation Daining Support OIKY anticipated completion	17/2013 1/2014 1/2014
J	This REQUIREME by: Based on observa review, the facility f patterns were suffic a timely and dignifi residents (R6, R29 R14, R37, R27, R9 resided in the facili Findings include: Observations on 10 revealed staffing pa room were not con needs in a dignified	0/28/13, and 10/30/13, atterns in the South dining sistent with meeting resident I manner for R6, R29, R19,		D. 1) Random Audits pre QA program 2) Reficient interview: need I desire upon admi- guantenly, y pren	9 1/2014 1/2014 1/2013
	to their call light red which resulted in e F241 R3, R94, R74, R7, of insufficient staffi R3's quarterly Mini 8/14/13, revealed F she was totally dep of daily living. During an interview reported the facility	R44. See F241 reported untimely responses quests for toileting assistance pisodes of incontinence. See and R120 reported concerns ng within the facility. mum Data Set (MDS) dated R3's cognition was intact and rendent on staff for all activities on 10/28/13, at 2:33 p.m. R3 was short staffed at ided, "They need more people			

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DGWP11

Facility ID: 00038

If continuation sheet Page 29 of 35

		AND HUMAN SERVICES & MEDICAID SERVICES						RM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRU	JCTION			DATE SURVEY COMPLETED
	T. T	245517	B. WING					0/31/2013
NAME OF F	PROVIDER OR SUPPLIER	· · · ·				STATE, ZIP COL	DE	
OAKLAW	IN HEALTH CARE CE	NTER		201 OAKLAN MANKATO	, MN 56001	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	CH CORRECT	PLAN OF CORR TIVE ACTION SI CED TO THE AF EFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 353	10/31/13, at 9:54 a. response time was shift.	ng a follow-up interview on m. R3 reported call light more problematic on the day	F 3	53				
	light logs provided k through 10/28/13, re 5:26 a.m. R3 waited for response to her waited 26 minutes a response. R94's quarterly MD was able to be under	ent print screen shots of call by the facility from 10/23/13 evealed that on 10/24/13, at 1 37 minutes and 19 seconds call light. At 10:35 a.m., she and 22 seconds for a S dated 10/4/13, revealed R94 erstood and had a clear						
	identified R94 requi most activities of da During an interview complained of untim within the facility. H on the toilet, it is 20 staff return. R94 re was a typical respon for assistance within	on 10/28/13, at 3:11 p.m. R94 hely assistance from staff le stated, "When they put you to 30 minutes," before the ported that 20 to 30 minutes hase time for call light requests in the facility. R94 stated that					•	
	He added, "[It is] lik somewhere else R94 indicated he di blame, rather he fel enough NAs. R74's annual MDS cognition was intact assistance for toilet hygiene. During an interview stated in response to patterns within the f	some are worse than others." d not feel the NAs were to t perhaps there were not dated 10/7/13, revealed R74's and he required extensive use, dressing and personal on 10/28/13, at 3:55 p.m. R74 to satisfaction with staffing acility, "That, they could do a						
	called in sick or cou	4 reported that when a staff Id not make it to work, they dded, "The aides are trying,		Facility ID: 00038				et Page 30 of 35

ORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES				FORM	D: 12/10/2013 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G			TE SURVEY MPLETED
		245517	B. WING				/31/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CI		E	
OAKLAW	/N HEALTH CARE CE	INTER		201 OAKLAWN AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORI	R'S PLAN OF CORRE RECTIVE ACTION SH RENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 353	Continued From pa	ace 30	F 35	3			
	but they can't get a	round to everyone."					
	Review of intermitte	ent print screen shots of call					
	light logs provided	by the facility from 10/23/13 evealed that on 10/26/13, at					
	6:13 a.m. R74 wait	ed 22 minutes and 56 seconds	-		-		
	for a response to h	is call light.					
	R7's quarterly MDS	6 dated 8/20/13, revealed R7's t, she was independent with					
	most activities of da	aily living and she required					
	physical assistance	e for bathing.			· ·		
	During an interview	on 10/28/13, at 4:13 p.m. R7					
	short of staff " She	at we're all saying, that they're e reported that the week prior,					
	she had to wait an	hour for her bath. She					
	indicated that resid	ents were always told to be					
	then had to sit and	the morning for baths, but wait for the aides to come.			÷ 1		
	During follow-up int	terview on 10/31/13, at 9:37					
	a.m. R7 verified he	r statements. She added that					
	the morning time w	as more problematic.R7 s often nervous because she					
	felt rushed to get re	eady for a meeting or an					-
	activity, but then ha	ad to sit and wait for the staff to					
	take her there.	ent print screen shots of call			·		
	light logs provided	by the facility from 10/23/13					
	through 10/28/13, i	revealed that on 10/24/13, at					
		d 32 minutes and 32 seconds					
	for a response to h	on 10/14/13. During interview					
	on 10/28/13, at 4:4	2 p.m. R120 reported					
	concerns of untime	ly care and services within the				÷	
	facility. She stated	, "When you have to sit on the and no one comes, they are					
	short on staff." Sh	he specified the day time was					
-	more problematic f	or untimely cares.					
	Review of intermitte	ent print screen shots of call					
	through 10/28/13. I	by the facility from 10/23/13 revealed that on 10/28/13, at					
ORM CMS-26	67(02-99) Previous Versions		11 F	Facility ID: 00038	if cont	inuation sheet	Page 31 of 35

		I AND HUMAN SERVICES				FORM	: 12/10/2013 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT CON	E SURVEY
	•	245517	B, WINC			10/31/2013	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN HEALTH CARE CI	ENTER	к +		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 353	7:21 a.m. R120 wa and 16 seconds for Interviews with a tw the family council r concerns of untime During interview wi (family-B) on 10/30 asked if she felt the meet the individual stated she was free the facility was offer that staff calling in wait to get the care During interview or family-A reported of during mealtimes.	ited one hour, three minutes r a response to her call light. vo family members, one being epresentative, corroborated ely care and services. ith family council representative 0/13, at 1:35 p.m. family-B was ere was adequate staffing to needs of residents. Family-B quently at the facility and felt en short of help. She stated frequently and residents had to	. F	353			
	staffing concerns v During an interview NA-G stated she d staffing within the in a timely manner people, not a facto to keep moving the her tasks done and that the residents of stresses me out." During an interview NA-J reported that order to complete verified that call lig She stated, "[The as guickly as they	ws also supported insufficient vithin the facility. v on 10/30/13, at 5:44 a.m. id not feel there was sufficient facility to meet resident needs . She added, "These are ry." She reported that she had ough cares in order to get all of d was not able to take the time deserved. She stated, "It v on 10/30/13, at 5:56 a.m. the felt she had to rush in all of her assigned tasks. She hts were not answered timely. call lights were] not answered should." She stated, "[1] go, go. The only time we can					

		AND HUMAN SERVICES						APPROVED 0938-0391
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		TIDU	E OCHOTELICTION			E SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						PLETED
		245517	B. WING				10/31/2013	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, Z	IP CODE		
OAKLAW	N HEALTH CARE CE	INTER			01 OAKLAWN AVENUE IANKATO, MN 56001			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF	CORRECTION	1	(X5) COMPLETION
PREFIX TAG	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPE		DATE
F 353	restorative nursing	ige 32 <sup>•</sup> r breaks." NA-J added that tasks were completed, "When e usually do not have time."		353		· ·		
	During interview on reported she felt the NA-D indicated that prevented more fall	e facility was short staffed. t she felt the facility could have is if they had more staff, but ide specific examples of an			• · · · · ·			
	occasion where a r response time by s of just having more are in need of some	esident fell in relation to poor taff. She added, "[It's] more eyes to catch when people ething the better." In addition, he had heard residents and						
	families ask NAs, ' also verified knowle insufficient staffing that the staffing pat the new administra (DON) came to the	"Can you slow down? " NA-D edge of family-A's concerns of within the facility. NA-D stated tterns did improve some, since tor and director of nursing facility. However, she						
	NA-K verified conc within the facility. S had to rush through	on 10/30/13, at 6:13 a.m. erns of insufficient staffing She reported that she felt she her cares and was unable to onses to resident needs.						
	During an interview NA-L reported insu prevented her from assistance to resid of the residents on	on 10/31/13, at 9:28 a.m. fficient staffing patterns providing timely care and ents. She reported that most the Southeast wing required				•	·	
. •	assigned three aid with morning cares go into the dining m assistance to resid facility's activity pro	sfers and the facility had only es. She reported that along a, the aides were expected to com to provide feeding ents. She added that the ograms began at 10:00 a.m. the NAs were not typically					•	
ORM CMS-2	able to assist all of 567(02-99) Previous Versions	the residents out of bed by	11	Fac	cility ID: 00038	If continuation	on sheet	Page 33 of 35

		AND HUMAN SERVICES						APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0		0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION			E SURVEY PLETED
		245517	B. WING			-	_ 10/:	31/2013
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STA	TE, ZIP CODE		
OAKLAV	/N HEALTH CARE CE	NTER	S.		01 OAKLAWN AVENUE //ANKATO, MN 56001			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN	OF CORRECTION	1	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED DEFIC	TO THE APPROPF	BE RIATE	DATE
F 353	that time. NA-L sta 12 hour shifts and t shifts in the coming Call light logs from were requested for R7, R120, R57 and provided due to the The facility's trackin isolate call light resp minutes as was req During an interview director of nursing ( began working at the she surveyed reside be done to improve She stated that the for more staffing co Since then, she did management staff the dining rooms. She have one manager for at least one hour residents. Howeve meals had been co process. Upon disc dining observations	ted that the NAs were working he facility had a lot of open weeks. 10/1/13 through 10/28/13, R14, R37, R27, R94, R74, R91 but were unable to be volume of data for printing. g system was also unable to bonse times greater than 20 uested. on 10/31/13, at 9:41 a.m. DON) reported that she e facility several months prior, ents and staff on what could their experience at the facility. most prominent response was verage in the dining rooms. implement a process for o sign up to assist daily in the reported that her goal was to nent staff covering each meal, r, to help with feeding r, she confirmed that not all nsistently covered by this cussion of the above noted , DON stated, "That should	F	353				
	not be happening." also not aware of in to untimely call light reported that she ex- would have been by manager and a grie untimely response of The DON confirmed facility's call light log patterns existed for She stated, "Our si system how it's sup	The DON stated she was continence episodes related response times. She cought forward to the care wance form completed so the could have been addressed. d she had not analyzed the gs to determine whether untimely response times. taff are not good at using the posed to be used those accurate." The DON cited		En	sility ID: 00038	If continuation	n sheet E	Page 34 of 35

STATEMENT OF DEFICIENCES AND PLAND OF CORRECTION       (X) PROVIDERSUPPLIER/LIDENTIFICATION NUMBER       (X) PROVIDER CATION NUMER       (X) PROVIDER CATION NUMBER       (X) PROVIDER CATION NUMER			AND HUMAN SERVICES & MEDICAID SERVICES			<u>.</u>	FORM	: 12/10/2013 APPROVED . 0938-0391
MAKE OF PROVIDER OR SUPPLIER     STREET ADDRESS CITY STATE, 2IP CODE       OAKLAWN HEALTH CARE CENTER     201 OAKLAWN AVENUE MARKATO, IM 8001       OWNED PRETX TAG     SUMMARY STATEMENT OF DEFICIENCES (PACH DEFICIENCY NUST BE PRECEDE BY FULL (PACH DEFICIENCY NUST BE PRECED BY (PACH DEFICIENCY NUST BE PRECED BY (PACH DEFICIENCY NUST BE PRECED SCIENCE)     Improvident SCIENT SCIENCE (PACH DEFICIENCY NUST BE PRECED BY (PACH DEFICIENCY NUST BE PRECED SCIENCE)     Improvide (PACH DEFICIENCY NUST BE PRECED BY (PACH DEFICIENCY NUST BE PRECED SCIENCE)     Improvide (PACH DEFICIENCY NUST BE PRECED SCIENCE)     Improv	STATEMENT	OF DEFICIENCIES	(X1). PROVIDER/SUPPLIER/CLIA					
DAKLAWN HEALTH CARE CENTER     281 OAKLAWN ARAUE       (A) D PREFX     SUMMARY STATEMENT OF DEFICIENCIES (EQUITOR FICENCY NUST BE PRECEDED BY PLL), REGULATORY OR LS DENTIFING INFORMATION)     D PREFX     PREVEX (COSS-REFTLAN OF CORRECTION (EQUITORS HARDON SHOULD BE COSS-REFTLEEDED TO THE APPROPRIATE DEFICIENCY)     COUNTRY (COSS-REFTLEEDED TO THE APPROPRIATE DEFICIENCY) <td></td> <td>м. С</td> <td>245517</td> <td>B. WING</td> <td><u>ب</u></td> <td></td> <td>10/</td> <td>31/2013</td>		м. С	245517	B. WING	<u>ب</u>		10/	31/2013
OAKLAWN HEALTH CARE CENTER     MANKATO, NN 66001       (PA) D PRETX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE BS FULL REGULATORY OR LSC DENTIFYING INFORMATION)     D PRETX TAG     PROVIDERS PARIO CORRECTIVE ACTION SHOLD BE CROSS-REFERENCE DEFICIENCY     Continued From page 34       F 353     Continued From page 34     F 353       several examples of occasions when call lights were inadvertently left on, though staff had already responded to the resident's concern. The DON reported that she did use the call light logs to investigate complaints or great- needident's call light as soon as possible. The call light procedure included the tollowing: "Turn off the signal light. Do what the resident do a prompty If sasitance is needed when you enter the room, summon heip by using the call signal." The procedure also intructed staff to document any complaints made by the resident in the resident's medical record.     Med. Call. System. Staff, Garay       "Our facility A Staffing Doloy revised 407, noted, "Our facility maintains adequate staffing on each shift to ensure that our resident sources outlined in their written plan of care.     Staff to Light to summer the dolowing on each services." The policy added that NAs were to be available to meet the needs of each resident as outlined in their written plan of care.	NAME OF I	PROVIDER OR SUPPLIER						
Preferx TAG       (EACH DERICIPACY NULS DEPRETEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)       PREFIX TAG       (EACH DORRECTIVAL CROSS-REFERENCE) TO THE APPROPRIATE DEPRETENCE TO THE APPROPRIATE DEPRETENCE TO THE APPROPRIATE DEPRETENCE TO THE APPROPRIATE DEPRETENCE TO THE APPROPRIATE       COMPLETION OWNER TAG         F 353       Continued From page 34 several examples of occasions when call lights were inadvertently left on, though staff had aready responded to the resident's concern. The DON reported that she did use the call light logs to investigate complaints or grievances related to a specified untimely call light response. The facility's Answring the Call Light policy revised 1010, directed staff to respond to a resident's call light so con as possible. The call light procedure included the following: "Turn off the signal light. Do what the resident tasks to you If you have promised the resident you will return with an item or information, do so prompty If assistance is needed when you enter the room, summon heip by using the call signal. The procedure also instructed staff to document any complaints made by the resident in the resident's medical record. The facility's Staffing policy revised 407, noted, "Our facility mains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services." The policy added that NAs were to be available to meet the needs of each resident as outlined in their written plan of care.       Sum 4 in 1114 At.	OAKLAW	VN HEALTH CARE CE	NTER			MANKATO, MN 56001		
several examples of occasions when call lights were inadvertently left on, though staff had already responded to the resident's concern. The DON reported that she did use the call light logs to investigate complaints or grievances related to a specified untimely call light response. The facility's Answering the Call Light policy revised 10/10, directed staff to respond to a resident's call light as soon as possible. The call light procedure included the following: "Turn off the signal light. Do what the resident saks of you If you have promised the resident was of you If you have promised the resident was of promptly If assistance is needed when you enter the room, summon help by using the call signal." The procedure also instructed staff to document any complaints made by the resident in the resident's medical record. The facility's Staffing policy revised 4/07, noted, "Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services." The policy added that NAs were to be available to meet the needs of each resident as outlined in their written plan of care.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BË	COMPLETION
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DGWP1 35		several examples of were inadvertently I already responded DON reported that a to investigate comp a specified untimely. The facility's Answer revised 10/10, direct resident's call light a light procedure inclu- the signal light Do you If you have pr return with an item promptly If assista enter the room, sun signal." The procect document any comp the resident's medic The facility s Staffin "Our facility maintai shift to ensure that services are met. L and licensed nursin and monitor the del services." The polic available to meet th outlined in their writ	f occasions when call lights eft on, though staff had to the resident's concern. The she did use the call light logs laints or grievances related to call light response. ring the Call Light policy ted staff to respond to a as soon as possible. The call uded the following: "Turn off what the resident asks of romised the resident you will or information, do so ance is needed when you mon help by using the call fure also instructed staff to oblaints made by the resident in cal record. g policy revised 4/07, noted, ns adequate staffing on each our resident's needs and licensed registered nursing g staff are available to provide ivery of resident care by added that NAs were to be e needs of each resident as ten plan of care.	Lo -M Ac -S-e	ok eec w	AT Call light pr B to be updared Call System - Statt Dourldge light by ms	Dicx - hav aswe hig G	



## 1/7/2014

#### Dear Sarah Grebenc,

I hope you will find satisfaction with the following Plan of Correction Addendum. Please let me know if t can be of further assistance and thank you for you assistance to complete necessary tasks properly!

#### F241

Audits: Dining Room audits will be completed by the Occupational Health and Learning (OHL) Director or designee one time each month for six months. Overall responsible party: the OHL Director to ensure audits are completed and identified issues are addressed.

#### F280

Specific To Resident: Resident care plan was updated and staff educated to resident(s) need. This was completed 11/2013. Addressed Concerns for Other Residents: Care Plan is individualized to each resident to enhance meeting specific care needs. Assessments and facility practice updated to include Tissue Tolerance and Braden Scale Assessments with residents with skin issues and those at risk for skin issues. Facility will continue weekly skin checks provided on resident bath day. Monitoring: Director of Nursing or Designee. Monitoring will be completed monthly by the DON or designee.

#### F282

Audits: Completed by the Director of Nursing or Designee month for six months. Overall responsible party: Occupational Health and Learning Director.

#### F311

Audits for completing ambulation programs will be conducted monthly for six months by the Occupational Health and Learning Director or Designee. Chart review audits will be completed by the Director of Nursing monthly for six months. Overall responsible party: Director of Nursing or Designee.

#### F314

Specific to Resident: Immediate education provided to staff caring for these residents to ensure adequate care is provided to each resident. Prevention recurrence: Assessment process evaluated nd added tissue tolerance assessments and re-education to Braden Scale provided to nursing staff. Audits: will include weekly skin checks with bath day and assessments are complet and care planned to meet resident need. Audits will be completed monthly by the Director of Nursing for six months.

> 201 Oaklawn Avenue, Mankato, MN 56001 p 507 388 2913 ( 507 388 1235 www.throcompany.com



### OAKLAWN HEALTH CARE CENTER The Thre Company

# **CONFIDENTIAL INFORMATION**

Email

DATE: 12/23/2013 1-7-2014

TO: Sarah Grebenc, Mn Dept Health

FAX#: email: Sjohnbon@throwmpany.com

FROM: Stacy Johnson Oaklawn Health Care Center

Phone: 507-388-2913 Fax: 507-388-1235

RE: Oaklawn Healthcare Center Plan of Correction

COMMENTS: THANK YOU!!!!!

THIS COVER SHEET IS PAGE 1 OF \_\_\_\_\_ PAGES.

IF YOU DO NOT RECEIVE LEGIBLE COPIES OF ALL PAGES, PLEASE CALL 507-388-2913

The information contained in this facsimile message is confidential information intended only for use of the individual or entity named above. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone, and return the original message to us at the above address via the U.S. Postal Service. Thank you.

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F315

Specific to resident needs: staff educated immediately to resident needs and expectation of toileting program, resident care plans updated to be more specific to resident needs. Audit process includes care plan and assessment monitoring by the Director of Nursing or Designee. Monitoring will be performed monthly for six months. Person who is overall responsible: Director of Nursing.

F353

Audits will include Dining Room and Assisted Dining Technique/Practices by the OHL Director or Designee. Audits will be conducted monthly for six months.

Date of correction: 12/12/2014

Thank you for your time and consideration with our Plan of Correction. Please let me know if I can be of further assistance.

R

Sincerely,

Stacy Johnson Oaklawn Healthcare Center 201 Oaklawn Avenue Mankato, Mn 56001 507-388-2913 sjohnson@throcompany.com

201 Oaklawn Avenue, Mankato, MN 56001

p 507.388.2913 / 507.388.1235 www.thiocompany.com

45517022

PRINTED: 11/25/2013 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING O		(X3) DATE SURVEY COMPLETED	
		245517	B. WING			05/2013
	ROVIDER OR SUPPLIER		20	REET ADDRESS, CITY, STATE, ZIP CO 1 OAKLAWN AVENUE ANKATO, MN 56001	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
K 000	INITIAL COMMEN	TS	K 000			
-73	ALLEGATION OF	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST		POC ok 12-13-14	1	
DC 12-10	PAGE OF THE CM USED AS VERIFIC UPON RECEIPT C ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	1S-2567 FORM WILL BE CATION OF COMPLIANCE. OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE		A F		
T: 10-31-13	Minnesota Departr Fire Marshal Divisi the time of this sur Center was found compliance with th participation in Me Subpart 483.70(a) 2000 edition of Na Association (NEPA	Survey was conducted by the nent of Public Safety, State on, on November 05, 2013. At vey, Oaklawn Health Care not to be in substantial re requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the tional Fire Protection Standard 101, Life Safety oter 19 Existing Health Care		RECEN	VED	
EXI	PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections			JAN - 8 MN DEPT. OF PUBL STATE FIRE MARSH	IC SAFETY	
	State Fire Marshal 445 Minnesota Str St. Paul, MN 5510	Division eet, Suite 145 1-5145, or		_		
14		DER/SUPPLIER REPRESENTATIVE'S SIG — RDN LD LNHAA an asterisk (*) denotes a deficiency which is the patients (See instruction	12/23	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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245517	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/08	5/2013
	PROVIDER OR SUPPLIER	INTER		NANKATO, MN 56001		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa By eMail to: Barbara.Lundberg( Marian.Whitney@s	@state.mn.us, and	К 000		-	
	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO	RRECTION FOR EACH THINCLUDE ALL OF THE DRMATION:		A. OHL DO'RECTOR COR	ucted /	_
	done to correct the	what has been, or will be, deficiency. oposed, completion date.	1	A. Otto Director cons quarterly audit pr to maintain on exc	end	11/2013'
	responsible for con	r title of the person rection and monitoring to ence of the deficiency.		B. QA PHOBAM	ļ	1/2013
	follows: The original buildin one-story in height, fully fire sprinkler p to be of Type II (00 The 1995 building / has a partial basen protected and was II(000) construction	Addition is one-story in height, nent, is fully fire sprinkler determined to be of Type 1.		C D. Continue quarter Bing decills per regulation	ly	"/2013
	detection in the cor corridors which is r department notifica	re alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion. The facility has a s and had a census of 72 at		240		
	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is enced by:				

PRINTED: 11/25/2013

				DLE CONSTRUCTION 3 01 - Main Building 01	(X3) DAT COM	(X3) DATE SURVEY COMPLETED		
		245517	B. WING			05/2013		
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
				201 OAKLAWN AVENUE				
AKLAW	IN HEALTH CARE CE	INTER		MANKATO, MN 56001				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APP	ROPRIATE	DATE		
TAG	REGULATORTOR			DEFICIENCY)				
			KOE		a.			
K 050	NFPA 101 LIFE SA	FETY CODE STANDARD	K 05					
SS=F	- I'lls and held	at uneveneted times under						
1	Fire drills are neid	at unexpected times under at least quarterly on each		1				
	obiff The staff is f	amiliar with procedures and is		1				
	aware that drills an	e part of established routine.						
1	Responsibility for p	blanning and conducting drills						
1	is assigned only to	competent persons who are						
	qualified to exercis	e leadership. Where drills are						
	conducted between	n 9 PM and 6 AM a coded						
	announcement ma	y be used instead of audible						
	alarms. 19.7.1.2			A time alarm he	875			
				A. fine alarm to completed. Docum Kicewed + Orapp to prevent necu	antho	1		
				completed. securit	enspires			
1		is not met as evidenced by:		11 NOWOD + STRAFT	edu cafel	*		
	Inis STANDARD	iew of available records, it was		Retained 100	NOT IN ED.	11/2013		
	determined the fac	ility had failed to conduct one		to prevent hell	riting			
	or more quarterly f	ire drills during the previous		,	)			
1	vear in accordance	e with NFPA 101 (2000)			3 <b>8</b> 2	-		
	Chapter 19. Sectio	n 19.7.1.2. In a fire		A Jostone company	4 Mul	1		
	emergency, this de	aficient practice could		D, Cherring Christian				
	adversely affect 77	of 77 residents.		-eully complete QU	Kong			
				B. Jesting compar Bully complete all Kequikements + do per kegulation	0			
	FINDINGS INCLU	DE:		Kegukement + do	ument			
	A 44/05/004 0 -14	4.40 AM while reviewing fire		Duchala		11/2013		
	On 11/05/2013 at	11:10 AM, while reviewing fire		per kegulation				
	arill reports provide	ed by facility staff, it was fire drills were conducted on				8		
	the PM Shift during	g 2nd Quarter of 2013.		A Elination of	Stoff	1		
	THE FIM-OTHER DOLLES			C. Education of completed	20	11/2013		
	This finding was co	onfirmed with facility staff.		completed		muis		
K 052	NFPA 101 LIFE SA	AFETY CODE STANDARD	K 053	2		0		
SS=F				D. Administrator Designer to ren Yorms & tetting to ensure complet	OK			
00-1	A fire alarm system	n required for life safety is		Ui MUINAILA	, int			
	installed, tested, a	nd maintained in accordance		Designee to ren	LIY	1		
	with NFPA 70 Natio	onal Electrical Code and NFPA		Alburg = Lohing	company	11/2013		
	72. The system ha	s an approved maintenance		Jucons o Troing		A CONTRACTOR		
	and testing program	m complying with applicable		to entitle complet	non is	done.		

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FORM APPROVED	
OND NO 0000 0004	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			0		0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245517	B. WING	_		11/	05/2013
NAME OF	PROVIDER OR SUPPLIER		- 231 - 211		TREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN HEALTH CARE CE	ENTER			201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 052		age 3 PA 70 and 72. 9.6.1.4	K	052			-
	Based upon a revi documentation, the building fire alarm a NFPA 101 (00) Cha Chapter 19, Sectio (1999 edition) Sect Table 7-3.1. In a fil practice could adver residents. FINDINGS INCLUE On 11/05/2013 at 1 the facility's Fire Ala 07/29/2013, eleven were noted on the documentation was locations, serial nu visual and function. Alarm Initiating Dev verified that visual device on the fire a properly conducted	<ul> <li>a facility falled to maintain the system in accordance with apter 9, Section 9.6 and n 19.3.4.1. and NFPA 72 ions 7-3.2 and 7-5.2.2 and re emergency, this deficient ersely affect 77 of 77</li> <li>DE:</li> <li>0:55 AM, during a review of arm Test Report dated (11) Manual Fire Alarm Boxes system, however, no a provided identifying the mbers, and outcomes for both al test results for each of these <i>r</i>ices. As such, it could not be and functional testing of each larm system had been</li> </ul>					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility (D; 00038

If continuation sheet Page 4 of 4