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

ID: DGWP
Facility ID: 00038

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

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial　2. Recertification
3. Termination　4. CHOW
5. Validation　6. Complaint
7. On-Site Visit　9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **1/9/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE　Date :
Sarah Grebenc, Unit Supervisor　01/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL　Date:
Kate JohnsTon, Enforcement Specialist　03/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **02/12/2014** (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)　020499

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,

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,

Sarah Grebenc

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245517	A. Building B. Wing	1/9/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	12/12/2013	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	12/12/2013	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	12/12/2013
ID Prefix F0311 Reg. # 483.25(a)(2) LSC	12/12/2013	ID Prefix F0314 Reg. # 483.25(c) LSC	12/12/2013	ID Prefix F0315 Reg. # 483.25(d) LSC	12/12/2013
ID Prefix F0353 Reg. # 483.30(a) LSC	12/12/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency ✓	10562	2/3/14	10562	2/3/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/31/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245517	A. Building / B. Wing: 01 - MAIN BUILDING 01	1/21/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	11/20/2013	ID Prefix Reg. # NFPA 101 LSC K0052	11/20/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency ✓	10562	2-3-14	10562	2-3-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/5/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: DGWP
Facility ID: 00038

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/31/2013** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HFE NE II 01/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

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

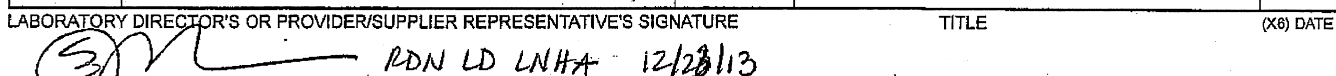
cc: Licensing and Certification File 5517s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING ______ B. WING ______	10/31/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation had been completed at the time of the standard recertification survey. Investigations of complaint H5517013 had been completed and had been substantiated. Deficiencies had been issued as a result of the substantiated findings at F353 and F241.	F 000	RECEIVED DEC 23 2013 MN Dept of Health St. Cloud	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified 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 ensure toileting assistance was provided in a dignified manner for 3 of 12 residents (R14, R37 and R27) reviewed for timely response to call light	F 241	a) 1. Hostess Program 2. NAR assignments adjusted 3. Diet Staff routine adjusted to help c̄ tray service instead of NAR 4. Cross training staff to assist in dining room b.) 1. Dining Room Supervision per policy 2. Care plan & Care Sheets updated 3. Communication c̄ /between NSS/NAR c̄ Daily huddles See addendum	10/2013 11/2013 12/2013 ongoing 10/2013 last training 1/23/2014 10/2013 11/2013 & ongoing 11/2013 & ongoing

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


RDN LD LNHA 12/23/13

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

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

PRINTED: 12/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/31/2013

NAME OF PROVIDER OR SUPPLIER: OAKLAWN HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 201 OAKLAWN AVENUE, MANKATO, MN 56001

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F 241	Continued From page 1 requests. Findings include: R6 was not provided with consistent and dignified eating assistance in the South dining room during the noon meal on 10/28/13. R6's quarterly Minimum Data Set (MDS) assessment dated 8/15/13, identified she had severely impaired cognition and required extensive assistance for eating. During a dining observation in the South dining room on 10/28/13, at 11:52 a.m. R6 was observed to receive her meal. Nursing assistant (NA)-I sat beside R6 and began to assist her with eating. NA-I was observed to place food on a spoon for R6 and then assisted her with placing the food into her mouth. At 11:53 a.m., NA-I stood up from the table and left, without communicating to R6. NA-I communicated to other staff in the dining room that she was going on her break. At 11:54 a.m., NA-C sat beside R6 and began to provide eating assistance. NA-C assisted R6 by placing the food onto the spoon and directing it into her mouth. R6 was observed to move the spoon to her mouth with cueing, on three occasions. At 11:55 a.m. NA-C stood up and left the dining room table without communicating to R6. R6 remained at the table, looking around, until 11:56 a.m. when the therapeutic recreation director sat beside her and began cueing and assisting her to eat. At 11:59 a.m., the therapeutic recreation director left R6, seated at the table and moved to a different table to assist another resident. R6 consumed about 25% of her meal and was wheeled out of the dining room at approximately 12:20 p.m., without any further eating assistance provided. R29, R19, R3, R85, R22 and R44 were not	F 241	C. 1) All Staff Education on DR expectations Flu education 2) DR requirements included on OHL/NAR on-boarding routine D. 1) Audits per QA routine Part 2 Dignity + Respect of Individual A. 1) Support services ↑ during meal times to ↑ Nsg time for resident care needs 2) Cross train of staff to enhance call light response B: 1) Charge Nurse Role 2) TMA role added to ↑ time availability Nsg for resident needs C. 1) QA program Flu c̄ residents 2) All staff education for expectation call light response D. Audits per QA routine	12/2013 1/15/2014 12/2013 1/2014 + ongoing 11/2013 11/2013 final training 1/2014 11/2013 12/2013 1/2014 + ongoing

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	245517	A. BUILDING ______ B. WING ______	10/31/2013

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F 241	Continued From page 2 provided with dignified eating assistance in the South dining room during the noon meal on 10/30/13. R29's care plan dated 8/21/13, indicated she was at risk for chewing/swallowing problems and required a soft diet with nectar thickened liquids. The care plan also noted, R29 had limited mobility and required extensive assistance for oral intake. R19's care plan dated 10/30/13, indicated she required a pureed diet, with pudding thickened liquids and was to be fed by staff. R19's quarterly MDS dated 8/28/13, identified her cognition was severely impaired and she was totally dependent on staff for eating. R3's care plan dated 9/6/13, indicated she required a pureed diet and honey thickened liquids. The care plan added that R3 needed to be fed by staff. Her quarterly MDS dated 8/14/13, identified her cognition was intact and she was totally dependent on staff for eating. R85's care plan dated 9/20/13, indicated she had a fair appetite, but required assistance and encouragement to eat. The care plan noted R85 required extensive assistance to eat and drink. R22's care plan dated 10/28/13, indicated she had chewing problems related to being edentulous (no teeth). The plan of care added, R22 required a soft or pureed diet and staff assistance was to be provided, as needed, for eating. R44's care plan dated 9/27/13, indicated he required a pureed diet with honey thick liquids.	F 241		

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F 241	Continued From page 3 The care plan also noted, R44 was able to feed himself, but did not always do so. Staff were directed to encourage him at meal times and assist with eating as needed. During a dining observation on 10/30/13, at 12:46 p.m. R29, R19, R3, and R85 were seated together at a table in the South dining room. R22 was seated at a different table, alone. R44 was seated at a third table, alone. R29, R19, R3, R85, R22 and R44 were observed seated quietly, with their food in front of them. NA-F was seated between R29 and R85. During the observation, NA-F gave R29 a bite of food and then turned to R85 with a bite of food. An unidentified staff member walked through the dining room. NA-F stated to that staff member, "Are you coming to help feed?" The unidentified staff member replied, "No, I'm going on break," and proceeded to walk out of the dining room. NA-F called to NA-A on her communication device (two-way radio) and asked if she was coming to help in the dining room. NA-A did not answer back. NA-F was then observed to stand up from her chair, walk over to the opposite side of the table, stand beside R19, and provide R19 with a bite of her food. NA-F then turned to R3 and while still standing, gave R3 a drink of her thickened liquid. NA-F proceeded to walk to the table where R44 was seated and asked R44, "Can you wake up for me?" Once awakened, NA-F gave R44 a spoonful of his food. NA-F returned to R85 and R29, sat down between them and gave a spoonful of food and a sip of liquid to R85. NA-F then turned to give R29 a spoonful of food. Visibly frustrated, NA-F used her communication device to state, "I really need help in the South dining room." At 12:52 p.m., dietary aide (DA)-A sat down between R19 and R3. DA-A indicated	F 241		

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F 241	Continued From page 4	F 241		

she was a nursing assistant, but was currently working as a dietary aide. She stated, "I haven't fed anyone in a long time." DA-A stated she was "supposed to be leaving," but would stay to help. At 1:00 p.m., NA-A came into the South dining room. DA-A then left the dining room and NA-A sat down between R19 and R3. NA-A and NA-F continued to offer bites of food to R29, R19, R3 and R85, while encouraging R22 and R44 to continue eating. At 1:17 p.m., R22 started coughing. NA-F went to her side, asked R22 if she was okay and wheeled her out of the dining room. Most of R22's food remained on her plate. NA-F returned to the dining room and continued to assist R29 and R85.

NA-F was interviewed on 10/30/13, at 1:40 p.m., while still feeding residents in the South dining room. NA-F reported, "There's supposed to be at least two aides in here. Today, we needed three." NA-F indicated R22 and R44 were supposed to be supervised while eating and R29, R19, R3, and R85 needed extensive or total assistance to eat. NA-F stated, "We're all tired of it. It's lack of staff, lack of training. It just keeps getting worse." NA-A stated this was a "typical" day. NA-F indicated the NAs started assisting the first shift of residents for the noon meal at 11:30 a.m. She added, "I've never understood why it takes so long to get through lunch...We [NA-F and NA-A] are both done at 2:30 p.m. and some aides are done at 2:00 p.m....We have to toilet everyone before we leave so it is sometimes 3:00 p.m. before we leave."
R14, R37 and R27 reported undignified care and services related to incontinent episodes, due to untimely response to their call light requests for toileting assistance.
R14's quarterly MDS dated 10/17/13, identified

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F 241	Continued From page 5 R14 with moderately impaired skills for daily decision making and required extensive assistance for transfers and toilet use. The MDS revealed R14 was always continent of bladder and a toileting program was in place to manage her urinary incontinence. The bladder assessment dated 7/11/13, noted, "[R14] is alert and oriented and clearly makes toileting needs known." The assessment identified R14 was continent of urine. Staff were to assist her and offer toileting assistance upon arising, before and after meals, at bedtime and as needed. The assessment added, "[R14] uses call-light at night to alert staff she needs the toilet." The written plan of care reviewed 8/28/13, revealed R14 was at risk for urinary incontinence related to impaired mobility and daily diuretic medication use. The care plan noted R14 was currently continent of bladder. Interventions included toileting upon rising in the morning, before and after meals and activities, before bedtime and as needed. The care plan added, "[R14] will call at night to use toilet." During an interview on 10/31/13, at 9:12 a.m. R14 verified she used her call light to request assistance from staff. She reported having to wait "a long time" for staff to respond to her requests. R14 reported she had been incontinent due to untimely response to her call light request for toileting assistance. She added, "It felt terrible." R37's admission MDS dated 10/1/13, revealed R37 was cognitively intact and required extensive assistance for toileting. The MDS identified R37 was occasionally incontinent of bladder and a toileting program was being used to manage her urinary incontinence. The Care Area Assessment (CAA) dated 10/1/13, identified R37 had urge	F 241		

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F 241	Continued From page 6 incontinence and functional incontinence. The CAA noted R37 received Detrol (a medication for treatment of overactive bladder), was offered toileting based on her toileting schedule and used her call light to request toileting assistance as needed. R37's care plan dated 10/7/13, identified she had occasional bladder incontinence related to impaired mobility. The care plan noted R37 required assistance to wash her hands, adjust her clothing, complete perinea cares and transfer onto and off of the toilet. Interventions revealed R37 was able to alert staff when she needed to use the bathroom. Interventions added, staff were to offer her toileting upon arising, before and after meals, at bedtime and as needed. In addition, overnight, R37 called for toileting assistance, but was to be checked for incontinence while repositioning. During an interview on 10/28/13, at 6:42 p.m. R37 reported she had experienced urinary incontinence as a result of untimely response to her call light. She stated, "They don't have enough girls working. I've rang my buzzer and it's taken a half hour for them to come... I've had accidents as a result... It's degrading." During a follow-up interview on 10/31/13, at 8:50 a.m. R37 verified her statements. She added that she experienced incontinence as a result of staff's untimely response to her request for toileting assistance on approximately three occasions in the past year. She again stated, "It's degrading." During interview on 10/30/13, at 6:10 a.m. NA-D verified R37 had an episode of incontinence as a direct result of staff's untimely response to her call light. R27's bladder assessment dated 4/26/13, revealed R27 was able to verbalize her needs and required limited assistance for raising and	F 241		

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F 241	Continued From page 7 lowing her clothing for toileting. The assessment noted R27 was occasionally incontinent of bladder, related to impaired mobility and cognitive impairments. The quarterly MDS dated 8/1/13, identified R27 had a moderate cognitive impairment and required extensive assistance for transfers and toilet use. The MDS also noted R27 was occasionally incontinent of bladder and a toileting program was in place to manage her urinary incontinence. The written plan of care dated 10/24/13, directed staff to offer R27 toileting assistance upon arising, before and after meals and at bedtime. Overnight, R27 was to be offered toileting if she appeared restless or if she requested. The plan of care noted R27 was alert and able to state when she needed to use the restroom. The plan added R27 was to be transferred on/off the toilet from a rolling walker with limited to extensive assistance of one staff. During an interview on 10/31/13, at 9:30 a.m. R27 reported incontinence due to untimely responses to her call light requests for toileting assistance. She indicated the most recent incident was approximately one week prior. R27 stated this made her feel "like a child." She added, the staff got busy and there were times she was left to "sit on the hard stool in the bathroom waiting for help to get out." The facility provided intermittent print screen shots of call light response times from 10/23/13, through 10/28/13. Review of this data revealed the following: On 10/25/13, at 5:44 a.m. R14 waited 24 minutes and 28 seconds for response to her call light. On 10/24/13, at 5:40 a.m. R37 waited 29 minutes and 59 seconds for response to her call light. On 10/25/13, at 5:43 a.m. R37 waited 28 minutes	F 241		

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F 241	Continued From page 8 and 19 seconds for response to her call light. On 10/23/13, at 6:18 p.m. R27 waited 23 minutes and nine seconds for response to her call light. On 10/24/13, at 6:01 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) reported that she began working at the facility several months prior, she surveyed residents and staff on what could be done to improve their experience at the facility. She stated that the most prominent response was for more staffing coverage in the dining rooms. Since then, she did implement a process for management staff to sign up to assist daily in the dining rooms. She reported that her goal was to have one management staff covering each meal, for at least one hour, to help with feeding residents. However, she confirmed that not all meals had been consistently covered by this process. Upon discussion of the above noted dining observations, DON stated, "That should not be happening." The DON stated she was also not aware of incontinence episodes related to untimely call light response times. She reported that she expected episodes such as this would have been brought forward to the care manager and a grievance form completed so the untimely response could have been addressed. The DON confirmed she had not analyzed the facility's call light logs to determine whether patterns existed for untimely response times. She stated, "Our staff are not good at using the system how it's supposed to be used ... those reports aren't very accurate." The DON cited 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	F 241		

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F 241	Continued From page 9 a specified untimely call light response.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan for 1 of 3 residents (R19) to identify an individualized repositioning schedule for a stage one pressure ulcer. Findings include: R19's care plan, dated 9/16/12, identified that R19 required extensive assistance with bed	F 280	A. 1) Care Plan will reflect individualized resident need B. Individualized care plan process C. Care plans will be reviewed @ initial, quarterly, and plan of care changes to ensure goals & interventions maintain individualized process. D. Audits per QA routine	11/2013 + on going 11/2013 + on going 11/2013 1/2014 + on going

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F 280	Continued From page 10 mobility. The care plan for skin identified R19 had unstagable pressure ulcer to lateral aspect of right heel. The goal was identified that R19 will not acquire additional skin breakdown through review date and the pressure ulcer on right heel will show signs of healing by review date. Interventions included: Follow MD/NP [physician and nurse practitioner] orders regarding wound care. Report changes in wound appearance. R19 to wear heel protector boots at all times. Lift, do not slide resident/use assistive devices to decrease friction/shear. Inspect skin daily, NAR [nursing assistants] to report any concerns to nurse. Weekly skin assessment by licensed staff. Moisturize dry skin. Bathe with mild soap, gently dry. Perform risk assessment/evaluation per protocol On 10/15/13, R19 was identified with a stage one pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence.) on her right elbow that measured 1 millimeter (mm) length by 1 mm width. On 10/29/13, the wound was measured 4 mm x 4 mm. The treatment plan identified R19 to have elbow protection, staff to turn and reposition resident every 2 hours. During an observation of resident cares on 10/30/13, R19 was assisted out of bed at 6:00 a.m. by nursing assistant NA-I. At 6:20 a.m., R19 was wheeled out of her room to the South day room and placed in front of the television in her wheelchair. At 6:44 a.m., R19 was observed seated in her wheelchair in dayroom and was observed to be leaning to left side with left arm pressed against wheelchair/ armrest. R19 was noted to have a positioning cushion on the left side of her chair but it was positioned too high to	F 280		

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F 280	Continued From page 11 support her from leaning. R19 remained in the dayroom seated in her wheelchair leaning to the left until 8:00 a.m. when staff wheeled her into the South dining room. At 9:25 a.m. R19 was wheeled back to the South dayroom and left seated in her wheelchair. R19 remained in her wheel chair. until 11:00 a.m. During an interview with Registered Nurse (RN)-A on 10/30/13, at 1:15 p.m. RN-A stated R19 had a repositioning schedule that correlated with her toileting schedule which was to toilet R19 upon rising then before/after meals, hour of sleep and during rounds on night. RN-A stated R19 should be repositioned at least every 2 hours. RN-A verified R19's care plan lacked any repositioning schedule for staff to follow and she stated she would have to correct the care plan.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident's plan of care was implemented as written, related to an ambulation program recommended by physical therapy (PT), for 1 of 4 residents (R106) reviewed for rehabilitation. In addition, the facility failed to ensure to follow the care plan for individualized repositioning needs to reduce the risk of development of pressure ulcers for 1 of 3	F 282	A. 1) Care Plan + Resident Care Sheets updated to include ambulation programs 2) Support services training B. 1) above 2) Individualized Schedules for careplan needs	11/2013 1/2014 11/2013

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F 282	Continued From page 12 residents (R9) who were reviewed for pressure ulcers and had a history of pressure ulcer development. Findings include: The facility did not follow R106's care plan for an ambulation program. R106's written plan of care, last reviewed on 10/28/13, identified her with limited physical mobility, related to generalized weakness, impaired cognition and activity intolerance due to her diagnoses. Goals for R106 included ambulation for short distances. Interventions directed, Ambulate [R106] to/from the bathroom and meals with one assist, walker and wheelchair to follow per PT... Follow direction provided by physical therapy. The nursing assistant (NA) care sheet for R106 updated 10/28/13, noted, Ambulate to/from the bathroom and meals with 1 [one] assist, walker, and wheelchair to follow. During observation on 10/30/13, at approximately 8:00 a.m. NA-I assisted R106 to use the bathroom in her resident room. R106's wheelchair was brought into the bathroom for transfer on and off the toilet. After using the bathroom, R106 was observed to self-propel her wheelchair to the North dining room for breakfast. NA-I did not ambulate R106 to/from the bathroom, nor to the breakfast meal. At 11:10 a.m., R106 was observed to ask NA-I if she was going to walk her to the dining room for lunch. NA-I replied that R106 could go herself. R106 then proceeded to self-propel her wheelchair to the North dining room for lunch. NA-I did not ambulate R106 to the lunch meal. During observation on 10/30/13, at 1:55 p.m. NA-B assisted R106 to utilize the bathroom in her resident room. R106's wheelchair was brought	F 282	C. 1) ambulation will be documented in facility clinical documentation tool 2) individualized care plan initiated D. 1) Ambulation programs monitored upon admission, quarterly, & c̄ plan of care changes per facility routine 2) Audits per QA routine	12/2013 11/2013 + 12/2013 12/2013 1/2014

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F 282	Continued From page 13 into the bathroom for transfers. Her walker was noted to be across her resident room, next to her recliner. NA-B did not walk R106 to/from the bathroom. During an interview on 10/30/13, at 2:05 p.m. registered nurse (RN)-B verified R106 was on an ambulation program where she was to be ambulated to/from meals and to/from the bathroom. Upon inquiry as to how she monitored that R106's ambulation program was implemented, RN-B reported that she did not know, other than to go by what she observed by chance. She confirmed she did not do audits to monitor implementation of resident care plans. Upon inquiry as to whether she routinely observed R106 being ambulated to/from meals, she confirmed that she had not. Rather, she added that she typically saw R106 self-propel in her wheelchair to meals. However, she insisted that staff did walk her to/from the bathroom. After discussion of the above noted observations, RN-B stated, "They should be walking with her." RN-B verified there was no formal documentation to evidence whether R106's ambulation program was being implemented. During an interview on 10/30/13, at 2:10 p.m. NA-B verified that to her knowledge, there was no ambulation program for R106. NA-B added, the activities program walked with R106 at times, but aside from walking with activities, she was not aware of needing to walk R106 to/from meals and to/from the bathroom. During an interview on 10/30/13, at 2:12 p.m. NA-I reported that R106 did not have an ambulation program. She added, to her knowledge, R106 only walked to/from some activities. During an observation on 10/30/13, at 2:39 p.m. NA-I was noted to use the wheelchair to transport	F 282		

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F 282	Continued From page 14 R106 into and out of her resident bathroom for toileting. NA-I did not ambulate R106 to/from the bathroom. During an interview on 10/31/13, at 8:37 a.m. activity director (AD) reported that R106 did routinely ambulate through the facility's activity program. She indicated that the activity program staff walked R106 at least three times weekly. During an interview on 10/31/13, at 8:56 a.m. PT verified she had recommended an ambulation program for R106, to walk to/from meals and to/from the bathroom. Upon inquiry as to whether R106 having been ambulated three times weekly by the facility's activity program was sufficient, PT replied it was not. She added that her expectation was that R106 was routinely ambulated to/from meals and to/from the bathroom to maintain or improve her joint movement, strength and stamina. During an interview on 10/31/13, at 9:41 a.m. director of nursing (DON) verified it was her expectation that facility staff implemented each resident's plan of care as written. She added NAs were expected to report any care plan tasks that were not completed to the RN, with an explanation of why the tasks were not completed. The facility's Using the Care Plan policy revised 8/06, revealed NAs were responsible for reporting to the RN when any care plan goals were not met or an expected outcome not achieved. The facility failed to follow the care plan for a repositioning schedule for R9 R9 was admitted to the facility on 7/2/13, and had a tissue profusion test conducted by the facility on 7/3/13, which identified she had a stage one pressure ulcer (Intact skin with non-blanchable	F 282	← Look @ Using the Care Plan Policy - Are we following policy? - Are Staff aware of Policy? (NAR + Nurses) - Need to make them aware + responsible for	

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F 282	Continued From page 15	F 282		

redness of a localized area usually over a bony prominence.) on her coccyx. The document identified R9 was able to tolerate sitting for one hour and lying for two hours without redness.

R9's care plan dated 8/13/13, identified her on a repositioning schedule as upon rising, before/after meals, bedtime, and during rounds on night.

During observation of morning cares on 10/30/13, at 6:20 a.m. nursing assistant (NA)-A was observed to enter R9's room and assist her out of bed. At 6:40 a.m., after completion of morning cares R9 was wheeled out into the North day room. R9 was observed to wheel herself around the facility in her wheelchair 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 breakfast. At 8:30 a.m., R9 completed her breakfast and wheeled herself out of the dining room. At 9:00 a.m., R9 remained in her wheelchair looking 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 55 minutes) from the last opportunity to reposition.

On 10/30/13, at 11:03 a.m. NA-B was interviewed and verified R9 had not been repositioned or toileted since she was assisted up for the day at 6:20 a.m. NA-B stated R9 informed staff when she needed to toilet. NA-B stated R9 was toileted and repositioned at the same time.

On 10/31/13, at 7:55 a.m. registered nurse (RN)-B was interviewed. RN-B stated R9 had improved in her overall health. RN-B stated when R9 was admitted she was at high risk for pressure ulcer development but she was now at a

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F 282	Continued From page 16 moderate risk. When asked how the facility developed the current repositioning schedule that could potentially have a resident repositioned at 5 hour intervals RN-B stated the concept of the toileting plan was for residents to be repositioned every two hours. RN-B verified over 2 1/2 hours was too long for a resident at risk for pressure ulcer development to wait to be repositioned.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement ambulation programs to maintain or improve ambulation abilities, for 1 of 4 residents (R106) reviewed for rehabilitation. Findings include: R106's quarterly Minimum Data Set (MDS) dated 10/16/13, revealed R106 required extensive assistance for transfers and toilet use. The MDS also noted R106 required limited assistance for walking in her room and on the unit. In addition, the MDS indicated R106 required the use of a walker and wheelchair for mobility. The care plan, last reviewed on 10/28/13, identified R106 with limited physical mobility, related to generalized weakness, impaired cognition and activity intolerance due to her diagnoses. Goals for R106 included ambulation for short distances. Interventions directed, Ambulate [R106] to/from the bathroom and meals	F 311	A. 1) Resident will be asked to walk per care plan direction 2) Staff educated to ambulation program c̄ daily huddle & changes B. 1) Residents need for ambulation program will be addressed on admission, quarterly, & plan of care changes & as resident need indicates necessity C. 1) Staff Education Flu Education 2) Support Services Education training to documentation	11/2013 11/2013 12/2013 12/2013 1/2014 1/2014

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F 311	Continued From page 17 with one assist, walker and wheelchair to follow per PT [physical therapy]... Follow direction provided by physical therapy. The nursing assistant (NA) care sheet for R106 updated 10/28/13, noted, Ambulate to/from the bathroom and meals with 1 [one] assist, walker, and wheelchair to follow. During an observation on 10/30/13, at approximately 8:00 a.m. NA-I assisted R106 to use the bathroom in her resident room. R106's wheelchair was brought into the bathroom for transfer on and off the toilet. After using the bathroom, R106 was observed to self-propel her wheelchair to the North dining room for breakfast. NA-I did not ambulate R106 to/from the bathroom, nor to the breakfast meal. At 11:10 a.m., R106 was observed to ask NA-I if she was going to walk her to the dining room for lunch. NA-I replied that R106 could go herself. R106 then proceeded to self-propel her wheelchair to the North dining room for lunch. NA-I did not ambulate R106 to the lunch meal. During an observation on 10/30/13, at 1:55 p.m. NA-B assisted R106 to utilize the bathroom in her resident room. R106's wheelchair was brought into the bathroom for transfers. Her walker was noted to be across her resident room, next to her recliner. NA-B did not walk R106 to/from the bathroom. During an interview on 10/30/13, at 2:05 p.m. registered nurse (RN)-B verified R106 was on an ambulation program where she was to be ambulated to/from meals and to/from the bathroom. Upon inquiry as to how she monitored that R106's ambulation program was implemented, RN-B reported that she did not know, other than to go by what she observed by chance. She confirmed she did not do audits to monitor implementation of resident care plans.	F 311	D. 1) Audits per QA routines 2) Monitoring on admission, quarterly, & PRN per facility routine.	2014 & ongoing 12/2013 & ongoing

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F 311	Continued From page 18 Upon inquiry as to whether she routinely observed R106 being ambulated to/from meals, she confirmed that she had not. Rather, she added that she typically saw R106 self-propel in her wheelchair to meals. However, she insisted that staff did walk her to/from the bathroom. After discussion of the above noted observations, RN-B stated, "They should be walking with her." RN-B verified there was no formal documentation to evidence whether R106's ambulation program was being implemented. During an interview on 10/30/13, at 2:10 p.m. NA-B verified that to her knowledge, there was no ambulation program for R106. NA-B added, the activities program walked with R106 at times, but aside from walking with activities, she was not aware of needing to walk R106 to/from meals and to/from the bathroom. During an interview on 10/30/13, at 2:12 p.m. NA-I reported that R106 did not have an ambulation program. She added, to her knowledge, R106 only walked to/from some activities. During observation on 10/30/13, at 2:39 p.m. NA-I was noted to use the wheelchair to transport R106 into and out of her resident bathroom for toileting. NA-I did not ambulate R106 to/from the bathroom. During an interview on 10/31/13, at 8:37 a.m. activity director (AD) reported that R106 did routinely ambulate through the facility's activity program. She indicated that the activity program staff walked R106 at least three times weekly. During an interview on 10/31/13, at 8:56 a.m. PT verified she had recommended an ambulation program for R106, to walk to/from meals and to/from the bathroom. Upon inquiry as to whether R106 having been ambulated three times weekly by the facility's activity program was sufficient, PT	F 311		

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F 311	Continued From page 19 replied it was not. She added that her expectation was that R106 was routinely ambulated to/from meals and to/from the bathroom to maintain or improve her joint movement, strength and stamina. During an interview on 10/31/13, at 9:41 a.m. director of nursing (DON) verified it was her expectation that facility staff implemented ambulation programs as indicated by each resident's written plan of care. She added NAs were expected to report any care plan tasks that were not completed to the RN, with an explanation of why the tasks were not completed. The facility's Goals and Objectives, Restorative Services policy revised 12/07, directed, Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify guidelines to develop individualized repositioning needs to reduce the risk of development of pressure ulcers	F 314	A. 1) Tissue Tolerance + Braden assessments 2) Nsg staff training complete Flu Education B. 1) Tissue Tolerance Assessment as assigned 2) Braden skin Asmt as assigned C. 1) Assessments assigned by DON or designee D. 1) Audits per QA routine	11/2013 12/2013 1/2014 11/2013 11/2013 11/2013 1/2014

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F 314	Continued From page 20	F 314		

for 2 of 3 residents (R9 and R19) who were reviewed for pressure ulcers and had a history of pressure ulcer development.

Findings include:

The facility failed to identify guidelines for a repositioning schedule for R9

R9 was admitted to the facility on 7/2/13, and had a tissue profusion test conducted by the facility on 7/3/13, which identified she had a stage one pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence.) on her coccyx. The document identified R9 was able to tolerate sitting for one hour and lying for two hours without redness.

R9's skin assessment dated 10/9/13, identified her at risk for skin breakdown related to impaired mobility, incontinence, and poor appetite. She was identified to need extensive assist of one staff with all mobility needs. The assessment identified R9 was assisted to reposition upon rising, before/after meals, bedtime, and night rounds.

R9's care plan dated 8/13/13, identified her on a repositioning schedule as upon rising, before/ after meals, bedtime, and during rounds on night.

On 9/10/13, R9 was identified on a Weekly Wound Note to have developed a stage 2 pressure ulcer on her right buttocks measuring 1.0 centimeters (cm) long by 0.5 cm wide.

During observation of morning cares on 10/30/13, at 6:20 a.m. nursing assistant (NA)-A was observed to enter R9's room and assist her out of

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F 314	Continued From page 21	F 314		

bed. At 6:40 a.m., after completion of morning cares R9 was wheeled out into the North day room. R9 was observed to wheel herself around the facility in her wheelchair 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 breakfast. At 8:30 a.m., R9 completed her breakfast and wheeled herself out of the dining room. At 9:00 a.m., R9 remained in her wheelchair looking 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 55 minutes) from the last opportunity to reposition.

On 10/30/13, at 11:03 a.m. NA-B was interviewed and verified R9 had not been repositioned or toileted since she was assisted up for the day at 6:20 a.m. NA-B stated R9 informed staff when she needed to toilet. NA-B stated R9 was toileted and repositioned at the same time.

On 10/31/13, at 7:55 a.m. registered nurse (RN)-B was interviewed. RN-B stated R9 had improved in her overall health. RN-B stated when R9 was admitted she was at high risk for pressure ulcer development but she was now at a moderate risk. When asked how the facility developed the current repositioning schedule that could potentially have a resident repositioned at 5 hour intervals RN-B stated the concept of the toileting plan was for residents to be repositioned every two hours. RN-B verified over 2 1/2 hours was too long for a resident at risk for pressure ulcer development to wait to be repositioned. When asked about reassessment of residents who developed pressure ulcers the RN stated she was not aware that R9 had developed a pressure ulcer 9/10/13, and stated there should

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F 314	Continued From page 22 have been a reassessment to identify if there were changing risk factors for development. The facility failed to identify guidelines for a repositioning schedule for R19. R19's 8/13/13, skin assessment identified her at moderate risk for skin breakdown per Braden scale assessment. R19 was to be turned and repositioned throughout the day with naps and toileting, and with routine rounds on nights. R19's 8/14/13, quarterly MDS identified her free of pressure ulcers. The assessment further identified R19 as dependent on staff for bed mobility, locomotion, dressing, toileting, and personal hygiene. On 10/15/13, R19 was identified with a stage one pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence.) on her right elbow that measured 1 millimeter (mm) length by 1 mm width. On 10/29/13, the wound was measured 4 mm x 4 mm. The treatment plan identified R19 to have elbow protection, staff to turn and reposition resident every 2 hours. R19's care plan, dated 09/16/12, identified that R19 required extensive assistance with bed mobility. The care plan for skin identified R19 had unstagable pressure ulcer to lateral aspect of right heel. The goal was identified that R19 will not acquire additional skin breakdown through review date and the pressure ulcer on right heel will show signs of healing by review date. Interventions included: Follow MD/NP [physician and nurse practitioner] orders regarding wound	F 314		

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care. Report changes in wound appearance. R19 to wear heel protector boots at all times. Lift, do not slide resident/use assistive devices to decrease friction/shear. Inspect skin daily, NAR [nursing assistants] to report any concerns to nurse. Weekly skin assessment by licensed staff. Moisturize dry skin. Bathe with mild soap, gently dry. Perform risk assessment/evaluation per protocol

During an observation of resident cares on 10/30/13, R19 was assisted out of bed at 6:00 a.m. by nursing assistant NA-I. At 6:20 a.m., R19 was wheeled out of her room to the South day room and placed in front of the television in her wheelchair. At 6:44 a.m., R19 was observed seated in her wheelchair in dayroom and was observed to be leaning to left side with left arm pressed against wheelchair/ armrest. R19 was noted to have a positioning cushion on the left side of her chair but it was positioned too high to support her from leaning. R19 remained in the dayroom seated in her wheelchair leaning to the left until 8:00 a.m. when staff wheeled her into the South dining room. At 9:25 a.m. R19 was wheeled back to the South dayroom and left seated in her wheelchair. R19 remained in her wheel chair. until 11:00 a.m.

During an interview with NA-A at 11:10 a.m. she stated R19 was toileted around 11:00 a.m. When asked when last toileted NA-A went to locate the NAR worksheet that indicated R19 was last toileted at 9:45 a.m. The worksheet did not identify who had toileted R19.

During an interview with RN-A on 10/30/13 1:15 p.m. she verified she had visited with staff related to toileting and repositioning R19. She stated staff

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F 314	Continued From page 24 informed her they did not toilet R19 at 9:45 a.m. but simply repositioned her by sliding her up in the wheelchair. RN-A stated R19 had a repositioning schedule that correlated with her toileting schedule which was to toilet R19 upon rising then before/after, hour of sleep and during rounds on night. RN-A stated R19 should be repositioned at least every 2 hours. RN-A verified R19 care plan lacked any repositioning schedule for staff to follow and she stated she would have to correct the care plan.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to maintain or enhance bladder function for 2 of 3 residents (R9 and R19) reviewed for incontinence. Findings include: R9 was not offered to use the toilet according to her individualized needs.	F 315	A. Individualized POC completed by facility RN B. 1) Individualized care plan 2) Staff Education to Individ. CP development 3) Care sheets to identify resident toileting plan C. Toileting/Bladder Assessments completed upon admission, quarterly & resident plan of care change per facility routine D. 1) Audits per QA routine 2) Continued staff education	11/2013 11/2013 12/2013 11/2013 11/2013 1/2014 12/2013

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F 315	Continued From page 25 The most recent bladder assessment conducted 7/8/13, identified R9 was incontinent of urine, with functional incontinence, related to impaired mobility. The assessment noted she was alert and oriented to self and family. R9 was unable to verbalize her toileting needs so staff were to anticipate her needs. R9's quarterly Minimum Data Set (MDS) assessment dated 10/21/13, identified she was occasionally incontinent with a toileting schedule. The MDS also noted she required extensive assistance for all activities of daily living (ADLs). R9's care plan dated 8/13/13, identified her with altered elimination related to impaired mobility, diuretic use, and impaired cognition. R9 was identified to be on a toileting schedule of upon rising, before/after meals, bedtime and during rounds on night. During observation of morning cares on 10/30/13, at 6:20 a.m. nursing assistant (NA)-A was observed to enter R9's room and assist her out of bed. At 6:40 a.m., after completion of morning cares, R9 was wheeled out into the North day room. R9 was observed to wheel herself around the facility in her wheelchair 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 breakfast. At 8:30 a.m., R9 completed her breakfast and wheeled herself out of the dining room. At 9:00 a.m., R9 remained in her wheelchair looking at the birds in the bird aviary in the North dayroom. R9 remained in her wheelchair without being toileted until 11:15 a.m. She was not toileted for a period of four hours and 55 minutes.	F 315		

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F 315	Continued From page 26 On 10/30/13, at 11:03 a.m. nursing assistant (NA)-B was interviewed and verified R9 had not been toileted. NA-B stated that R9 informed staff when she needed to toilet. NA-B stated R9 was occasionally incontinent of urine. NA-B stated she was unaware of a toileting schedule for R9. On 10/31/13, at 7:55 a.m. registered nurse (RN)-B was interviewed. RN-B stated R9 had improved in her overall health. RN-B stated, when R9 was admitted, she was frequently incontinent of urine, but now was occasionally incontinent. When asked how the facility developed the current toileting schedule, which could potentially allow a five hour interval between toileting, RN-B stated that the concept of the toileting plan was for residents (including R9) to be toileted every two hours. RN-B verified that a period of over two and a half hours was too long for a resident to wait between toileting. R19 was not offered to use the toilet according to her individualized needs. R19's MDS and Care Area Assessment (CAA) dated 5/22/13, identified R19 was incontinent of urine with risk factors that included: restricted mobility, and urgency of urine. R19's care plan dated 9/10/12, identified she required extensive assistance with toileting and her plan for incontinence maintenance was to toilet upon rising, before/after meals and activities and check/change during routine night rounds. During observation of resident cares on 10/30/13, R19 was assisted out of bed at 6:00 a.m. by NA-I. At 6:20 a.m., R19 was wheeled to the South day	F 315		

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F 315	Continued From page 27 room and placed in front of the television in her wheelchair. At 6:44 a.m., R19 was observed seated in her wheelchair in the dayroom. R19 remained in the dayroom until 8:00 a.m., when staff wheeled her into the South dining room. At 9:25 a.m., R19 was wheeled back to the South dayroom and left seated in her wheelchair. R19 remained in her wheel chair until 11:00 a.m. At 11:10 a.m., NA-A was interviewed and stated she toileted R19 at 6:00 a.m. (five hours from last toileting). NA-A verified R19 was incontinent of urine when toileted at 11:00 a.m. During interview with RN-A on 10/30/13, at 1:15 p.m., she verified she had visited with staff related to toileting R19. RN-A stated R19 had a toileting schedule which was to toilet her upon rising, then before/after meals and activities, at bedtime and during rounds overnight. RN-A stated R19 should have been toileted at least every two hours.	F 315		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353	A. 1) Hostess program initiated 2) NAR assignments adjusted 3) Cross Training of staff 4) Dietary routine changed 5) Addition TMA program B. 1) above 2) DC supervision per facility policy	10/2013 11/2013 To Be completed 1/2014 12/2013 10+11/2013 10/2013

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F 353	Continued From page 28 section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staffing patterns were sufficient to meet resident needs in a timely and dignified manner, for 14 of 70 residents (R6, R29, R19, R3, R85, R22, R44, R14, R37, R27, R94, R74, R7, and R120) who resided in the facility. Findings include: Observations on 10/28/13, and 10/30/13, revealed staffing patterns in the South dining room were not consistent with meeting resident needs in a dignified manner for R6, R29, R19, R3, R85, R22 and R44. See F241 R14, R37 and R27 reported untimely responses to their call light requests for toileting assistance which resulted in episodes of incontinence. See F241 R3, R94, R74, R7, and R120 reported concerns of insufficient staffing within the facility. R3's quarterly Minimum Data Set (MDS) dated 8/14/13, revealed R3's cognition was intact and she was totally dependent on staff for all activities of daily living. During an interview on 10/28/13, at 2:33 p.m. R3 reported the facility was short staffed at mealtimes. She added, "They need more people	F 353	C. 1) All staff education c̄ Flu education 2) Training support services anticipated completion D. 1) Random audits per QA program 2) Resident interview of need/desire upon admission, quarterly, + PRN	12/2013 1/2014 1/2014 1/2014 11/2013

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F 353	Continued From page 29 to help feed." During a follow-up interview on 10/31/13, at 9:54 a.m. R3 reported call light response time was more problematic on the day shift. Review of intermittent print screen shots of call light logs provided by the facility from 10/23/13 through 10/28/13, revealed that on 10/24/13, at 5:26 a.m. R3 waited 37 minutes and 19 seconds for response to her call light. At 10:35 a.m., she waited 26 minutes and 22 seconds for a response. R94's quarterly MDS dated 10/4/13, revealed R94 was able to be understood and had a clear comprehension of others. The MDS also identified R94 required extensive assistance for most activities of daily living. During an interview on 10/28/13, at 3:11 p.m. R94 complained of untimely assistance from staff within the facility. He stated, "When they put you on the toilet, it is 20 to 30 minutes," before the staff return. R94 reported that 20 to 30 minutes was a typical response time for call light requests for assistance within the facility. R94 stated that the staff seemed rushed while providing cares. He added, "[It is] like they need to get somewhere else ... some are worse than others." R94 indicated he did not feel the NAs were to blame, rather he felt perhaps there were not enough NAs. R74's annual MDS dated 10/7/13, revealed R74's cognition was intact and he required extensive assistance for toilet use, dressing and personal hygiene. During an interview on 10/28/13, at 3:55 p.m. R74 stated in response to satisfaction with staffing patterns within the facility, "That, they could do a little more on." R74 reported that when a staff called in sick or could not make it to work, they worked short. He added, "The aides are trying,	F 353		

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F 353	Continued From page 30 but they can't get around to everyone." Review of intermittent print screen shots of call light logs provided by the facility from 10/23/13 through 10/28/13, revealed that on 10/26/13, at 6:13 a.m. R74 waited 22 minutes and 56 seconds for a response to his call light. R7's quarterly MDS dated 8/20/13, revealed R7's cognition was intact, she was independent with most activities of daily living and she required physical assistance for bathing. During an interview on 10/28/13, at 4:13 p.m. R7 stated, "That's what we're all saying, that they're short of staff." She reported that the week prior, she had to wait an hour for her bath. She indicated that residents were always told to be ready right away in the morning for baths, but then had to sit and wait for the aides to come. During follow-up interview on 10/31/13, at 9:37 a.m. R7 verified her statements. She added that the morning time was more problematic. R7 stated that she was often nervous because she felt rushed to get ready for a meeting or an activity, but then had to sit and wait for the staff to take her there. Review of intermittent print screen shots of call light logs provided by the facility from 10/23/13 through 10/28/13, revealed that on 10/24/13, at 6:24 a.m. R7 waited 32 minutes and 32 seconds for a response to her call light. R120 was admitted on 10/14/13. During interview on 10/28/13, at 4:42 p.m. R120 reported concerns of untimely care and services within the facility. She stated, "When you have to sit on the bedpan for an hour and no one comes, they are short on staff." She specified the day time was more problematic for untimely cares. Review of intermittent print screen shots of call light logs provided by the facility from 10/23/13 through 10/28/13, revealed that on 10/28/13, at	F 353		

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7:21 a.m. R120 waited one hour, three minutes and 16 seconds for a response to her call light. Interviews with a two family members, one being the family council representative, corroborated concerns of untimely care and services.
During interview with family council representative (family-B) on 10/30/13, at 1:35 p.m. family-B was asked if she felt there was adequate staffing to meet the individual needs of residents. Family-B stated she was frequently at the facility and felt the facility was often short of help. She stated that staff calling in frequently and residents had to wait to get the cares they needed.

During interview on 10/28/13, at 3:37 p.m. family-A reported concerns of insufficient staffing during mealtimes. Family-A stated the staff had to run to assist residents with needs during mealtime.

Employee interviews also supported insufficient staffing concerns within the facility.

During an interview on 10/30/13, at 5:44 a.m. NA-G stated she did not feel there was sufficient staffing within the facility to meet resident needs in a timely manner. She added, "These are people, not a factory." She reported that she had to keep moving through cares in order to get all of her tasks done and was not able to take the time that the residents deserved. She stated, "It stresses me out."
During an interview on 10/30/13, at 5:56 a.m. NA-J reported that she felt she had to rush in order to complete all of her assigned tasks. She verified that call lights were not answered timely. She stated, "[The call lights were] not answered as quickly as they should." She stated, "[I] always have to go, go, go. The only time we can

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slow down is on our breaks." NA-J added that restorative nursing tasks were completed, "When we have time ... we usually do not have time."
During interview on 10/30/13, at 6:10 a.m. NA-D reported she felt the facility was short staffed. NA-D indicated that she felt the facility could have prevented more falls if they had more staff, but was unable to provide specific examples of an occasion where a resident fell in relation to poor response time by staff. She added, "[It's] more of just having more eyes to catch when people are in need of something the better." In addition, NA-D stated that she had heard residents and families ask NAs, "Can you slow down? " NA-D also verified knowledge of family-A's concerns of insufficient staffing within the facility. NA-D stated that the staffing patterns did improve some, since the new administrator and director of nursing (DON) came to the facility. However, she reported there had not been sufficient improvement.
During an interview on 10/30/13, at 6:13 a.m. NA-K verified concerns of insufficient staffing within the facility. She reported that she felt she had to rush through her cares and was unable to provide timely responses to resident needs.
During an interview on 10/31/13, at 9:28 a.m. NA-L reported insufficient staffing patterns prevented her from providing timely care and assistance to residents. She reported that most of the residents on the Southeast wing required two people for transfers and the facility had only assigned three aides. She reported that along with morning cares, the aides were expected to go into the dining room to provide feeding assistance to residents. She added that the facility's activity programs began at 10:00 a.m. each morning, that the NAs were not typically able to assist all of the residents out of bed by

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F 353	Continued From page 33 that time. NA-L stated that the NAs were working 12 hour shifts and the facility had a lot of open shifts in the coming weeks. Call light logs from 10/1/13 through 10/28/13, were requested for R14, R37, R27, R94, R74, R7, R120, R57 and R91 but were unable to be provided due to the volume of data for printing. The facility's tracking system was also unable to isolate call light response times greater than 20 minutes as was requested. During an interview on 10/31/13, at 9:41 a.m. director of nursing (DON) reported that she began working at the facility several months prior, she surveyed residents and staff on what could be done to improve their experience at the facility. She stated that the most prominent response was for more staffing coverage in the dining rooms. Since then, she did implement a process for management staff to sign up to assist daily in the dining rooms. She reported that her goal was to have one management staff covering each meal, for at least one hour, to help with feeding residents. However, she confirmed that not all meals had been consistently covered by this process. Upon discussion of the above noted dining observations, DON stated, "That should not be happening." The DON stated she was also not aware of incontinence episodes related to untimely call light response times. She reported that she expected episodes such as this would have been brought forward to the care manager and a grievance form completed so the untimely response could have been addressed. The DON confirmed she had not analyzed the facility's call light logs to determine whether patterns existed for untimely response times. She stated, "Our staff are not good at using the system how it's supposed to be used ... those reports aren't very accurate." The DON cited	F 353		

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F 353	Continued From page 34 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 asks of you... If you have promised the resident you will return with an item or information, do so 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.	F 353	Look at call light policy - needs to be updated - have new call system - staff answer/acknowledge light by pushing Green "staff in" light.	

OAKLAWN
HEALTH CARE CENTER
The Thro Company

1/7/2014

Dear Sarah Grebenc,

I hope you will find satisfaction with the following Plan of Correction Addendum. Please let me know if I 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 f 507.388.1235
www.throcompany.com

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CONFIDENTIAL INFORMATION

~~FAX COVER SHEET~~
Email

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

TO: Sarah Grebenc, Mn Dept Health

~~FAX #:~~ email: sjohnson@throcompany.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

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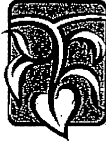

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F315

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.

Per email communication with administrator date of correction for all tags is 12/12/13

Sincerely,

Stacy Johnson

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

F5517022

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	11/05/2013

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 05, 2013. At the time of this survey, Oaklawn Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok 1-13-14	

DC 12-10-13

EXIT: 10-31-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RDN LD LNHA — (X6) DATE: 12/23/13

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

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K 000	Continued From page 1 By eMail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Oaklawn Health Care Center was constructed as follows: The original building was constructed in 1964, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II (000) construction; The 1995 building Addition is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 77 beds and had a census of 72 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	A. OHL Director corrected quarterly audit process to maintain or exceed compliance. B. QA program + C D. Continue quarterly fire drills per regulation	11/2013 11/2013 11/2013

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K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based upon a review of available records, it was determined the facility had failed to conduct one or more quarterly fire drills during the previous year, in accordance with NFPA 101 (2000) Chapter 19, Section 19.7.1.2. In a fire emergency, this deficient practice could adversely affect 77 of 77 residents. FINDINGS INCLUDE: On 11/05/2013 at 11:10 AM, while reviewing fire drill reports provided by facility staff, it was confirmed that no fire drills were conducted on the PM-Shift during 2nd Quarter of 2013. This finding was confirmed with facility staff.	K 050	A. Fire alarm tests completed. Documentation reviewed & staff educated to prevent recurrance B. Testing company will fully complete all testing requirements & document per regulation C. Education of staff completed D. Administrator or Designee to review forms c̄ testing company to ensure completion is done.	11/2013 11/2013 11/2013 11/2013
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	K 052		

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K 052	Continued From page 3 requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based upon a review of available documentation, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1. and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and Tàble 7-3.1. In a fire emergency, this deficient practice could adversely affect 77 of 77 residents. FINDINGS INCLUDE: On 11/05/2013 at 10:55 AM, during a review of the facility's Fire Alarm Test Report dated 07/29/2013, eleven (11) Manual Fire Alarm Boxes were noted on the system, however, no documentation was provided identifying the locations, serial numbers, and outcomes for both visual and functional test results for each of these Alarm Initiating Devices. As such, it could not be verified that visual and functional testing of each device on the fire alarm system had been properly conducted. This finding was confirmed with the chief building engineer.	K 052		