

#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 3004 April 12, 2016

Ms. Chantel Peterson, Administrator Oaklawn Care & Rehabilitation Center 201 Oaklawn Avenue Mankato, Minnesota 56001

Subject: Oaklawn Care & Rehabilitation Center - IDR

Provider # 245517 Project # S5517027

Dear Ms. Peterson:

This is in response to your letter of February 11, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag 42 CFR 483.65 F441 issued pursuant to the survey event GX6B11, completed on January 14, 2016.

The information presented with your letter, the CMS 2567 dated January 14, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Health Regulation Division staff have been carefully considered and the following determination has been made:

F441 S/S-F 42 CFR 483.65 (n) Infection Control: The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

#### §483.65(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.
- §483.65(b) Preventing Spread of Infection
- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. §483.65(c) Linens

Oaklawn Care & Rehabilitation Center April 12, 2016 Page 2

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

#### Summary of the facility's reason for IDR of this tag:

The facility indicated they maintain an efficient Infection Control Program that reflects the trending and analysis of data collected to reduce the risk of transmission even though they have not formalized it in writing specific infection trending and analysis patterns.

#### Summary of Facts:

The facility provides and documents annual education to staff for infections control on topics such as transmission based precautions, influenza prevention as well as education for criteria to record urinary tract infections, skin, soft tissues and mucosal infections, gastrointestinal tract infections, and respiratory infections.

The policy and procedure titled Reporting Mechanism for Infection Control, not dated, identified an infection control nurse lists the infections and completes the monthly report form, employee infection data is reported, and compliance with infection control practices are monitored and documented.

The policy and procedure titled Infection Control Surveillance, dated September 24, 2011, identified data to collect, but did not identify how the facility utilizes the information to investigate, control, and prevent infections in the facility.

According to additional information provided by the facility, a daily Monday through Friday, undocumented and informal process occurs at the facility when nurse managers' report to the Occupational Health and Learning Registered Nurse (OHL RN) specific infections, antibiotic use, and symptoms for all residents on their units. The data reported to the OHL RN would then be tracked and analyzed to reduce the potential infection. The nursing assistants, nurses, and nurse managers provide ongoing surveillance. The OHL RN then utilizes the data collected daily, Monday through Friday, by completing the monthly analysis that focuses on tracking and patterns of infections that were present in the facility.

The monthly data gathered on the form titled Continuous Quality Improvement, Monthly Resident Infection Statistics were reviewed for July, August, September, October, November and December of 2015. The form did not have data and/or sufficient data that infections were followed in the facility that would support the information collected during the facilities undocumented and informal process of surveillance, tracking, and trending that would identify patterns, conclusions, actions, or outcomes of an infection control program. There were no investigations or analysis of infections with the intention to detect the source, determine how to control the infection, and to reduce or prevent the potential of infections in the facility.

This is a valid deficiency at this tag and at the correct Scope and Severity of F (Widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy).

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

Oaklawn Care & Rehabilitation Center April 12, 2016 Page 3

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

Sincerely,

A. Wusan

Annette Winters, Supervisor Office of Health Facility Complaints Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64970 St Paul, MN 55164-0970

Office 651-201-4204 Fax: 651-281-9796

General Info: 651-201-4201 Toll Free: 1-800-369-7994

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Jessica Sellner, St. Cloud Team B Unit Supervisor

**IDR Review Response Letter** 

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GX6B

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

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY A	GENCY		Facility ID: 00038
MEDICARE/MEDICAID PROVIDER N     (L1) 245517  2.STATE VENDOR OR MEDICAID NO.	О.	3. NAME AND ADI (L3) <b>OAKLAWN</b> ( (L4) <b>201 OAKLAW</b>	CARE & REHAE		N CENTER		4. TYPE OF ACTI  1. Initial  3. Termination	ON: <u>7 (</u> L8)  2. Recertification 4. CHOW
(L2) <b>953692000</b>		(L5) MANKATO,	MN		(L6)	56001	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) <b>07/01/2015</b>	NERSHIP	7. PROVIDER/SUP	PPLIER CATEGORY	Y 09 ESRD	<u>02</u> (L7	7) 22 CLIA	7. On-Site Visit  8. Full Survey Aft	9. Other er Complaint
6. DATE OF SURVEY <b>04/15</b> 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC	/ <b>2016</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR END	DING DATE: (L35)
2 AOA 3 Other		10 70 00 00 000	IG GERTHELER 1G					
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):		X A. In Complian  Program Rec Compliance	nce With quirements		2. Tec 3. 24	chnical Personnel	Following Requirements  6. Scope of  7. Medical I  8. Patient Ro	Services Limit Director
12.Total Facility Beds	<b>77</b> (L18)	1. A	acceptable i OC		_	e Safety Code	9. Beds/Roo	
13.Total Certified Beds	<b>77</b> (L17)	_	pliance with Program and/or Applied Waiv		* Code:	A*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY	MEETS		
18 SNF 18/19 SNF 77	19 SNF	ICF	IID		1861 (e) (1) o	r 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK		HOW LTC CANCELL		2016, is r	escinded eff	fective 4/14/2	016.	
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY API	PROVAL	Date:
Larry Gannor	n, DSFM		04/15/2016	(L19)	Kate Jo	hnsTon, Pr	ogram Specia	alist 05/09/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OR	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Pari  2. Facility is not Eligible			IPLIANCE WITH C	IVIL	2.		al Solvency (HCFA-2572 nterest Disclosure Stmt (I	
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	ENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION 02/01/1988	BEGINNING I	DATE	ENDING DATE	Е	VOLUNTARY 01-Merger, Clos			UNTARY to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction	on W/ Reimbursemer	nt 06-Fail	to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE A. Suspension of		(L44)		03-Risk of Involution 04-Other Reason	untary Termination  for Withdrawal	OTHEF 07-Prov 00-Acti	vider Status Change
(L27)	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	06201		(L31)	Posted 05/0	9/2016 Co.		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DAT	ГЕ				
	(L32)	<i>↓ 20   1   1   1   1   1   1   1   1   1   </i>		(L33)	DETERMIN	ATION APPRO	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24-5517 May 5, 2016

Ms. Chantel Peterson, Administrator Oaklawn Care & Rehabilitation Center 201 Oaklawn Avenue Mankato, Minnesota 56001

Dear Ms. Peterson:

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

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

Effective April 14, 2016 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.

Oaklawn Care & Rehabilitation Center May 5, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

May 5, 2016

Ms. Chantel Peterson, Administrator Oaklawn Care & Rehabilitation Center 201 Oaklawn Avenue Mankato, Minnesota 56001

RE: Project Number S5517027

Dear Ms. Peterson:

On January 27, 2016, we informed you that the following enforcement remedy was being imposed:

State Monitoring, effective February 23, 2016. (42 CFR 488.422)

On February 25, 2016, The Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

 Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective April 14, 2016. (42 CFR 488 subpart F)

Also, we notified you in our letter of , in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 14, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on January 14, 2016, and a Federal Monitoring Survey (FMS) completed on February 10, 2016. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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 April 15, 2016, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 14, 2016, and a Federal Monitoring Survey (FMS) completed on February 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 14, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 14, 2016, as of April 15, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and

Oaklawn Care & Rehabilitation Center May 5, 2016 Page 2

Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of February 25, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 14, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 14, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 14, 2016, is to be rescinded.

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

Enclosed are copies of the Post Certification Revisit Forms, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

#### POST-CERTIFICATION REVISIT REPORT

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NAME OF	FACILITY							STREET	ADDRESS, CIT	Y, STATE, ZIF	CODE	•	
OAKLAW	'N CARE	& REH	HABILITATI	ON CENTER				201 OAK	LAWN AVENUE				
								MANKA	O, MN 56001				
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Y4				Y5	Y4				Y5	Y4			Y5
ID Prefix	F0282			Correction	ID Prefix	F0311			Correction	ID Prefix	F0323		Correction
Reg.#	483.20(k)	(3)(ii)		Completed	Reg.#	483.25(	a)(2)		Completed	Reg.#	483.25(h)		Completed
LSC				02/23/2016	LSC				02/23/2016	LSC			02/23/2016
ID Prefix	F0441			Correction	ID Prefix				Correction	ID Prefix			Correction
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1/14/2016

FOLLOWUP TO SURVEY COMPLETED ON

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

### **POST-CERTIFICATION REVISIT REPORT**

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	R / SUPPLI CATION NU			MULTIPLE CONS A. Building 01 - B. Wing	TRUCTION MAIN BUIL	.DING 0	1				Y2	DATE O 4/15/20	F REVISIT
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		0 DEL	ЈАВИ ІТАТ	ION CENTER				l	KLAWN AVENUE		CODE		
OAKLAW	N CARE	X KEI	IADILITAT	ION CENTER					TO, MN 56001				
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program, corrected provision	to show the	nose of late su nd the	deficiencie uch correc	es previously repo ctive action was a	orted on the ccomplished	CMS-25 d. Each	567, Staten deficiency	nent of D should b	eficiencies and be fully identifie	Plan of Cor d using eithe	ent Amendments rection, that have er the regulation o of each requirem	r LSC	
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Reg.#	NFPA 101			Completed	Reg. #	NFPA 1	01		Completed	Reg. #	NFPA 101		Completed
LSC	K0050			02/23/2016	LSC	K0154			02/11/2016	LSC	K0155		02/11/2016
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FOLLOWUP TO SURVEY COMPLETED ON 1/14/2016							DEFICIENCIES CMS-2567) SEN			YES	s 🔲 no		

#### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245517 <sub>Y1</sub>	B. Wing	Y2	4/15/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAWN CARE & REHABILITAT	TION 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).

ITEI	М	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	PA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0022	03/11/2016	LSC KOO	)25	04/14/2016	LSC	K0027		04/01/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	PA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0034	04/01/2016	LSC KOO	)38	03/07/2016	LSC	K0056		04/14/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	PA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0062	04/01/2016	LSC K01	146	04/14/2016	LSC	K0147		04/01/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
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FOLLOWUP TO SURVEY COMPLETED ON 2/10/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				з 🗆 по			

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GX6B

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY A	AGENCY	F	Facility ID: 00038
MEDICARE/MEDICAID PROVIDER N     (L1) 245517  2.STATE VENDOR OR MEDICAID NO.	NO.	3. NAME AND AD (L3) OAKLAWN (L4) 201 OAKLA'	CARE & REHAI		N CENTER		4. TYPE OF ACTION:  1. Initial  3. Termination	2 (L8) 2. Recertification 4. CHOW
(L2) <b>953692000</b>		(L5) MANKATO,	MN		(L	.6) 56001	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) <b>07/01/2015</b>	NERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (	(L7) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other mplaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	4/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	E	FISCAL YEAR ENDING 09/30	DATE: (L35)
2 AOA 3 Other  11. LTC PERIOD OF CERTIFICATION		10 THE EACH ITY	IC CERTIFIED AC.					
From (a): To (b):		A. In Complia Program Re Compliance	equirements e Based On:		2. T	Fechnical Personnel 24 Hour RN	Following Requirements:  6. Scope of Servi 7. Medical Direct	tor
12.Total Facility Beds	<b>77</b> (L18)	1. A	Acceptable POC			7-Day RN (Rural SNF)	<del>_</del>	Size
13.Total Certified Beds	<b>77</b> (L17)		npliance with Progran and/or Applied Waiv			Life Safety Code <b>B*</b>	9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOWN		requirements	and of Applied Walk	013.	* Code: 15. FACILIT		(112)	
18 SNF 18/19 SNF 77	19 SNF	ICF	IID			or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLE S	HOW LTC CANCELI	LATION DATE):					
17. SURVEYOR SIGNATURE Date :					18. STATE S	URVEY AGENCY API	PROVAL	Date:
Mary Rogers, HPR Soc	cial Work Sp	<u>ecialis</u> t	02/17/2016	(L19)	Kate JohnsTon, Program Specialist 03/10/2016 (L20)			
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE O	R SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Par			MPLIANCE WITH C HTS ACT:	TIVIL	:		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
2. Facility is not Eligible	(L21)							
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OF PARTICIPATION 02/01/1988	BEGINNING		ENDING DAT		VOLUNTAR' 01-Merger, Cl	<u>00</u>	INVOLUNT	
(L24)	(L41)		(L25)		02-Dissatisfac	ction W/ Reimbursemer	nt 06-Fail to Me	eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI		(L44)			voluntary Termination son for Withdrawal	OTHER 07-Provider 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	(LTT)				***************************************	
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARK	KS		
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	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DA	ГЕ	Posted 03	3/14/2016 Co.		
	(L32)	02/02/2016		(L33)	DETERMI	NATION APPRO	VAI.	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2564 January 27, 2016

Ms. Chantel Peterson, Administrator Oaklawn Care & Rehabilitation Center 201 Oaklawn Avenue Mankato, Minnesota 56001

RE: Project Number S5517027

Dear Ms. Peterson:

On January 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

<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;

Oaklawn Care & Rehabilitation Center January 27, 2016 Page 2

<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:

Jessica Sellner, Unit Supervisor Minnesota Department of Health Licensing & Certification Health Regulation Division Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7343

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 February 23, 2016, 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 February 23, 2016 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**

Oaklawn Care & Rehabilitation Center January 27, 2016 Page 4

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

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

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 14, 2016 (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

Oaklawn Care & Rehabilitation Center January 27, 2016
Page 5
this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 14, 2016 (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 Health Regulation Division 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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525 Oaklawn Care & Rehabilitation Center January 27, 2016

Page 6

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services Midwest Division of Survey and Certification Chicago Regional Office 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519



CMS Certification Number (CCN): 245517

### February 25, 2016 By Certified Mail and Facsimile

Ms. Chantel Peterson, Administrator Oaklawn Care & Rehabilitation Center 201 Oaklawn Avenue Mankato, MN 56001

Dear Ms. Peterson:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND

NOTICE OF IMPOSITION OF REMEDY

Cycle Start Date: January 14, 2016

#### STATE SURVEY RESULTS

On January 14, 2016, a health survey and a Life Safety Code survey were completed at Oaklawn Care & Rehabilitation Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level F, cited as follows:

• F441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens.

The State agency advised you of the deficiency that led to this determination and provided you with a copy of the survey reports (CMS-2567).

#### FEDERAL MONITORING SURVEY

In addition, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on February 10, 2016. As the surveyor informed you during the exit conference, the FMS has revealed that your facility continues to not be in substantial compliance. The FMS found deficiencies, with the most serious being at S/S level F, cited as follows:

- K56 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K146 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K147 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS are enclosed with this letter on form CMS-2567.

•

#### PLAN OF CORRECTION

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Joseph Frye, RN, Health & Life Safety Specialist Centers for Medicare & Medicaid Services Division of Survey and Certification 233 North Michigan Avenue, Suite 600 Chicago, Illinois 60601-5519 Or by Email: Joseph.Frye@cms.hhs.gov

#### INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR §488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Stephen Pelinski, Survey Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;

- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for <u>all</u> cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

#### LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is April 14, 2016.

#### SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, we are imposing the following remedy:

 Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective April 14, 2016

The authority for the imposition of remedies is contained in 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

#### DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective April 14, 2016 if your facility does not achieve compliance within the required three months. This action is mandated by the Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR § 488.417(b). We will notify National Government Services that the denial of payment for all new Medicare admissions is effective on April 14, 2016. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective April 14, 2016.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care

plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

#### **TERMINATION PROVISION**

If your facility has not attained substantial compliance by July 14, 2016, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §§ 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and §489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR §489.57 will apply.

#### NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 14, 2016, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Oaklawn Care & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 14, 2016. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

#### **APPEAL RIGHTS**

This formal notice imposed:

 Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective April 14, 2016

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at <a href="https://dab.efile.hhs.gov/user\_sessions/new">https://dab.efile.hhs.gov/user\_sessions/new</a> to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that <u>all</u> hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Nancy K. Rubenstein, Director 330 Independence Avenue, SW

# Cohen Building, Room G-644 Washington, D.C. 20201

A request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice.

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

#### **CONTACT INFORMATION**

If you have any questions regarding the Federal Monitoring LSC survey, please contact Joseph Frye, Nurse Consultant, Health & Life Safety Specialist, at (312) 886-2567. Joseph Frye's fax number is (443) 380-6577. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

/s/

Jean Ay
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)

cc: Minnesota Department of Health

Minnesota Department of Human Services Office of Ombudsman for Older Minnesotans

Stratis Health

PRINTED: 01/27/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPL	
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	Department's accepte bottom of the first page be used as verification Upon receipt of an accepted	ance. Your signature at the ge of the CMS-2567 form will n of compliance.	,			
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F 282 SS≃D	completed and found		F 28	1. R37 care plan has be	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
	must be provided by	d or arranged by the facility qualified persons in resident's written plan of		R69 oral care will be plan.     Corrective actions will	provided per care	
	This REQUIREMENT is not met as evidence by: Based on observation, interview, and record review, the facility falled to provide cares according to the resident's written plan of care 2 of 4 residents (R37, R69) reviewed for activity of daily living (ADLs).			ensure the alleged defice not re occur: The OHL, if will conduct weekly audit following oral and groom plans. Audits will continux 3 months and gradual	DON or designee its for NARs ning care per care ue 4x per month illy decrease	
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_ABORATORY I	DIRECTORS OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	M III]LE	(0	Ke) DATE

Any deficiency statement ending with an asteriak (\*) 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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	of deficiencies FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E GONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	R37's significant char (MDS) dated 11/25/18 moderate cognitive in extensive assistance personal hygiene.  R37's care plan, dated had oral/dental health multiple missing teeth denture, and a lower pincluded, "Provide set oral cares. He is able  During observation and 5:53 p.m. R37 was observed which were covered which were covered which were covered which were covered with a decause it didn't fit were drank cold liquids. R37's bottom natural to be covered with a viction of the covered with a viction of the covered with a with a mouth.  During observation on was sitting on the toiled (NA)-F performed pentransferred R37 from the with a mechanical lift, room into the common breakfast. Although N assisting R37 with his not offered oral cares  When interviewed on stated R37's dentures	age Minimum Data Set 5, Indicated R37 had spairment, and required of one staff for dressing and d 12/3/15, indicated R37 problems related to , and had a full upper coartial. Interventions up assist as needed for to brush his own teeth."  ad interview on 1/11/16, at served with no upper teeth, teeth on the front bottom with a whitish substance. crushed his teeth in, "A long ways wear his top plate all and would fall out when On 1/12/16, at 4:10 p.m. teeth were again observed whitish matter and dark no denture or partial in his	F 282	4. Care plans reviewed by nurse may of each unit to ensure oral and groot care are addressed appropriately for individual resident.  5. NARs have an individual skills recompetency on oral and grooming of Corporate Education Director, DON or designee.  6. NARs and nurses will review the and grooming cares/care plan expert. Compliance of oral care per care be reviewed in quarterly QA/CQI met. 8. Facility will be in compliance by February 23, 2016.	ming r each view/ eare by , OHL oral ctations plan wil

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	ION CENTER		21	TREET ADDRESS, CITY, STATE, ZIP CODE D1 OAKLAWN AVENUE TANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	the dentures in the mistated she did not put went and asked the misteeth in and R37 r NA-F pushed R37 bathrashed his bottom padhesive, and placed searched the cabinet stated she did not third dentures. NA-F state assistance in finding if the room. While NA-F I going to get to scrub came back into R37's both began looking in denture and it was lostlowly picked up his tapplied toothpaste witto brush his bottom mote to the bathroom and a brushing. NA-F brush denture adhesive, an R37's mouth. NA-F parea of the North wind table for breakfast. Rhis teeth in and state since he had them in Review of the Oral/Drame and in the company of the Oral/Drame and state since he had them in Review of the Oral/Drame and in the company of the Oral/Drame and in the company of the Oral/Drame and in the company of the Oral/Drame and in the case of the Oral/Drame and in the company of the Oral/Drame and in the company of the Oral/Drame and in the case of the Oral/Drame and it was not the oral of	oming. morning. NA-F in R37's dentures, and esident if he wanted to put epiled, "Well, why not?" ck into his bathroom, artial, appiled denture It in his mouth. NA-F for R37's top denture and nk R37 had any top d she needed to ask for R37's top denture, and left was gone, R37 asked, "Am o my teeth today?" NA-F is room with NA-G and they in R37's room for his top cated in R37's room. R37 oothbrush from the sink, th some difficulty, and began atural teeth. NA-F returned assisted R37 to finish and the top denture, applied d placed the denture in ushed R37 into the common g, and placed him at the dit had been a long time  ental Evaluation dated for had a brand new upper or partial denture, and had a Also included, R37 had d the summary noted, "Staff do oral cares and assist pro at is able to brush his own	F	282			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245517	B. WING			01/	14/2016
	ROVIDER OR SUPPLIER	ION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE D1 OAKLAWN AVENUE MANKATO, MN 68001		
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X6) COMPLETION DATE
F 282	refused oral cares an of his mouth, howeve and encouraging oral residents plan of care.  R69's quarterly MDS the resident had seve diagnosis including durequired extensive as hygiene including bru.  R69's care plan dated resident required assincluding oral cares, assist with washing fateeth, and to provide morning, bedtime, an During observation of at 7:54 a.m. NA-A as R69 was able to was after being provided assisted the resident perineal care, combing glasses. No oral can R69 during the observated she was compand stated no oral care and stated no ora	d often took his dentures out r, staff should be offering cares dally according to the e.  dated 10/28/15, identified are cognitive impairment had ementia and anxiety, and saist of one staff for personal shing his teeth and shaving.  d 11/6/15, directed staff ist of one with grooming and to set up resident to ace and hands and brushing assistance with oral cares d as needed.  f morning cares on 1/13/16, sisted R69 to the bathroom. In his face independently with the washcloth, and NA-A with dressing, providing and his hair, and putting on the was provided or offered to revation.  I/13/15, at 8:16 a.m. NA-A stated she believed	F	282			
	stated he liked to bru	I/14/16, at 9:10 a.m. R69 sh his teeth when he gets up over, he was not sure if staff ushing his teeth.					

CLITICIT	OT OIL MEDICARE OF	AICDICAID SEVAICES				CHIE LAC	<u>7. 0830-038 (</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245517	B. WNG_		7000	01/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
UVAKI VANI	I CARE & REHABILITATI	ON CENTER		20	01 OAKLAWN AVENUE		
VARLAN	CARE & KENABILITATI	ON CENTER .		M	MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 282	Continued From page	4	F 2	282	·		
		14/16, at 9:15 a.m. RN-A to be provided twice per sistants.					,
	stated oral cares were	1/14/16, at 9:23 a.m. NA-B s to be provided and/ or d should offer assistance or					
	stated oral cares were with cares in the morn R69's care plan indica grooming and oral car	14/16, at 11:10 a.m. RN-B expected to be completed ing and at bedtime, and ted assist of one staff for es, and staff should be assistance with oral cares ents plan of care.			1. R37 care plan has been updated	for oral	
		Routine Care included, ag and out at bedtime. Give ag and at bedtime." ENT/SERVICES TO	FS	311	cares to be assist of one. Oral care was be provided per care plan.  2. R69 oral care will be provided per plan. Care plan and NAR care sheet	care s have	
		appropriate treatment and r Improve his or her abilities (a)(1) of this section.			been updated to assist of one with s 3. Corrective actions will be monitore ensure the alleged deficient practice not re occur: The Corporate Education	ed to will	
	by: Based on observation review, the facility fails with grooming for 2 of	is not met as evidenced  n, interview, and document ed to provide assistance 4 residents (R37, R69) who ce with personal hygiene.			Director, OHL, DON or designee will conduct weekly audits to ensure ora and grooming is being completed products will continue 4x per month x 3	l cares operly.	
	Findings include:				months and gradually decrease audidata allows.	ts until	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	TIPLE CONSTRUCTION (X3) DATE COMI			SURVEY LETED
		245517	B. MNG			01/	14/2016
	ROVIDER OR SUPPLIER	ION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 11 OAKLAWN AVENUE ANKATO, MN 58001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	i TE	(X5) COMPLETION DATE
F 311	R37's diagnosis noted dated 6/9/11, included disorder, and cognitive R37's significant char (MDS) dated 11/25/18 moderate cognitive in extensive assistance personal hygiens. R37's care plan, upda had oral/dental health multiple missing teath denture and a lower pincluded, "Provide seroral cares. He is able During observation at 5:53 p.m. R37 was of and had a few natural which were covered with a very and he didn't abecause it didn't fit whe drank cold liquids. R37's bottom natural to be covered with a very particles, and he had mouth.  During observation or was sitting on the toil (NA)-F performed per transferred R37 from with a mechanical lift, room into the commo breakfast. Although Nanches (MB) at the commo breakfast.	d on the admission record of osteoarthritis, anxiety e decline.  Inge Minimum Data Set 5, indicated R37 had appairment, and required of one staff for dressing and lated 12/3/15, indicated R37 in problems related to 1, and had a full upper partial. Interventions the up assist as needed for to brush his own teeth."  Indicated R37 had a full upper partial. Interventions the passist as needed for to brush his own teeth."  Indicated R37 had performed to determine the foot set of	F	311	Audits will be completed for a rando sample of residents each week to error care and grooming is being con and offered to residents individual of the NARs will be inserviced by Corported and Director, DON, OHL or designee on offering and providing poral cares and grooming per residencare plan.  5. NARs and nurses will review and agree that they understand proper Acares for all residents.  6. Review compliance of grooming cares in the quarterly QA/CQI meet 7. Facility will be in compliance by February 23, 2016.	nsure npleted are plan orate proper nt sign to ADL and oral	

OFILITY	S FOR MEDICARE &	MEDICAID SERVICES .				OMD MC	J. USJU-038 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COMF	ESURVEY PLETED
		245517	B. WING		,	01/	/14/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OVE VIII	N CARE & REHABILITAT	ION CENTED		1	201 OAKLAWN AVENUE		
OARLAW	A CARE OF KENABILITAL	ONGENIER		1	MANKATO, MN 58001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 311	Continued From page not offered oral cares  When interviewed on stated R37's dentures night and then she as the dentures in the mistated she couldn't re to put his dentures in the mistated she couldn't re to put his dentures R37 if he wanted to postated, "Well, why not into his bathroom, bruapplied denture adher mouth. NA-F searche denture and stated she top dentures. NA-F c assistant care sheet (resident cares) and stand lower [dentures].' R37's top denture, NA ask for assistance, an was gone, R37 asked my feeth today?" NA-room with NA-G and the R37's room for his top up his toothbrush from toothpaste with some brush his bottom natures.	during the observation.  1/13/16, at 8:20 a.m. NA-F were usually brushed at sisted the resident to put orning. moming. NA-F member if she helped him and walked over to R37 were not in. NA-F esked ut his teeth in and R37 '?" NA-F pushed R37 back ished his bottom partial, sive, and placed it in his d the cabinet for R37's top le did not think R37 had any hecked the nursing which directs staff on lated, "It says he has upper "When she could not locate has the says he has upper "When she could not locate has stated she needed to a left the room. While NA-F is, "Am I going to get to scrub F came back into R37's they both began looking in denture. R37 slowly picked"		311	DEFICIENCY)	WE	
	denture adhesive, and R37's mouth. NA-F th common area of the N at the table for breakf to have his teeth in ar time since he had the	ed the top denture, applied d placed the denture in en pushed R37 into the North wing, and placed him ast. R37 stated it felt good nd stated it had been a long					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR M	MEDICARE &	MEDICAID SERVICES					. 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION	(X3) DATE COMPI	
		245517	B. WNG			01/	14/2016
NAME OF PROVIDER OR SUPPLIER  OAKLAWN CARE & REHABILITATION CENTER				2	STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 68001		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE
Minnea 5/11/15 celculu through 'Persol stay on Needs Review 11/20/1 full den several poor or to remi [as need teeth with the resident several poor or to remi [as need teeth with the resident several poor or to remi [as need teeth with the resident several poor or to remi [as need teeth with the resident several poor or to remi [as need teeth with the resident several poor or to remi [as need teeth with the resident several poor or to remi [as need teeth, mornin pouring the resident several poor or to remi [as need teeth, mornin pouring the resident several poor or to remi [as need teeth, mornin pouring the resident several poor or to remi [as need teeth, mornin pouring the remi pour or to remi [as need teeth, mornin pouring the remi pour or to remi [as need teeth, mornin pour or to remi [as need teeth with pour or to remi [as need	i, Indicated R3 is and heavier nout the remainal Oral Hygle is each area for to use daily provided in the Oral/D is, included R3 included R3 included R3 included R4 included R4 included R5 included R5 included R5 included R5 included R6 including oral cares are including oral care plan date including oral cares, with washing it and to provide ing, bedtime, and observation or including including oral cares, with washing it and to provide ing, bedtime, and observation of including including including oral cares, with washing it and to provide ing, bedtime, and observation of including including including including including oral cares, with washing it and to provide ing, bedtime, and it is not included incl	s Administration dated 7 had moderate amounts of amounts of plaque found ning teeth. Also included, ne: poor. Patient needs to a longer amount of time. roxy brush!"  ental Evaluation dated 37 had a brand new upper er partial denture, and had a Also included, R37 had d the summary noted, "Staff do oral cares and assist prn at is able to brush his own  on 1/13/16, at 2:26 p.m. a)-D stated R37 occasionally d often took his dentures out er, staff should be offering a cares dally.  dated 10/28/15, identified ere cognitive impairment had desist of one staff for personal ushing his teeth and shaving.  d 11/6/15, directed staff that sist of one with grooming and to set up resident to face and hands and brushing assistance with oral cares	F	.311			

Fact the resident with dressing, provided or offered to R69 during the observation.  Additional observations of R69 on 1/13/16, at 11:08 a.m., and 1/14/16, at 9:10 a.m., the resident remained unshaven.  During Interview on 1/13/15, at 8:16 a.m. NA-A stated R69 was able to resident. NA-A stated R69 was able to referred to the resident. NA-A stated R69 was able to perform oral cares and shaving independently.  During interview on 1/13/16, at 3:39 p.m. R69 on 1/13/16, at 11:08 a.m., and 1/14/16, at 9:10 a.m., the resident remained unshaven.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST	RUCTION		(X3) DATE COMP	SURVEY LETED
OAKLAWN CARE & REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 311  Continued From page 8 cheeks approximately four millimeters (mm) in length, and chin hair approximately two mm.  On 1/12/16, at 3:39 p.m. R69 was observed in the dayroom, watching television and remained unshaven.  During observation of morning cares on 1/13/16, at 7:54 a.m. NA-A assisted R69 to the bathroom. R69 was able to wash his face independently after being provided with the washcloth, and NA-A assisted the resident with dressing, providing perineal care, combing his hair, and putting on glasses. No oral care or shaving was provided or offered to R69 during the observation.  Additional observations of R69 on 1/13/16, at 11:08 a.m., and 1/14/16, at 0:10 a.m., the resident remained unshaven.  During interview on 1/13/15, at 8:16 a.m. NA-A stated she was completed or offered to the resident. NA-A stated R69 was able to perform oral cares and shaving independently.  During interview on 1/14/16, at 9:10 a.m. R89			245517	B. WNG	**************************************			01/	14/2016
PREFIX TAG  (EACH DEFICIENCY MUST BE PECCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 311  Continued From page 8 cheeks approximately four millimeters (mm) in length, and chin hair approximately two mm.  On 1/12/16, at 3:39 p.m. R69 was observed in the dayroom, watching television and remained unshaven.  During observation of morning cares on 1/13/16, at 7:54 a.m. NA-A assisted R69 to the bathroom. R69 was able to wash his face independently after being provided with the washcloth, and NA-A assisted the resident with dressing, providing perineal care, combing his hair, and putting on glasses. No oral care or shaving was provided or offered to R69 during the observation.  Additional observations of R69 on 1/13/16, at 11:08 a.m., and 1/14/16, at 9:10 a.m., the resident remained unshaven.  During Interview on 1/13/15, at 8:16 a.m. NA-A stated she was completed with cares for R69, and stated no oral care or shaving was completed or offered to the resident. NA-A stated R69 was able to perform oral cares and shaving independently.  During interview on 1/14/16, at 9:10 a.m. R69			TION CENTER		201 OAK	LAWN AVENUE			
cheeks approximately four millimaters (mm) in length, and chin hair approximately two mm.  On 1/12/16, at 3:39 p.m. R69 was observed in the dayroom, watching television and remained unshaven.  During observation of morning cares on 1/13/16, at 17:54 a.m. NA-A assisted R69 to the bathroom. R69 was able to wash his face independently after being provided with the washcloth, and NA-A assisted the resident with dressing, providing perineal care, combing his hair, and putting on glasses. No oral care or shaving was provided or offered to R69 during the observation.  Additional observations of R69 on 1/13/16, at 11:08 a.m., and 1/14/16, at 9:10 a.m., the resident remained unshaven.  During interview on 1/13/15, at 8:16 a.m. NA-A stated she was completed with cares for R69, and stated no oral care or shaving was completed or offered to the resident. NA-A stated R69 was able to perform oral cares and shaving independently.  During interview on 1/14/16, at 9:10 a.m. R69	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A	SHOULD BE	TE	(X8) COMPLETION DATE
stated he liked to brush his teeth when he gets up in the morning, however, he was not sure if staff assisted him with shaving or brushing his teeth.  During interview on 1/14/16, at 9:15 a.m. RN-A stated oral cares were to be provided twice per day by the nursing assistants.  When interviewed on 1/14/16, at 9:23 a.m. NA-B stated oral cares were to be provided and/ or	F 311	cheeks approximate length, and chin half length, and chin half On 1/12/16, at 3:39 dayroom, watching trunshaven.  During observation at 7:54 a.m. NA-A a R69 was able to war after being provided assisted the resident perineal care, combiglasses. No oral care offered to R69 durit 11:08 a.m., and 1/1-resident remained to During Interview on stated she was compand stated no oral correct to the resident to perform oral independently.  During interview on stated he liked to brin the morning, how assisted him with simple performing interview on stated oral cares we day by the nursing tweethers.	ly four millimeters (mm) in approximately two mm.  p.m. R69 was observed in the elevision and remained  of morning cares on 1/13/16, assisted R69 to the bathroom. In the face independently with the washcloth, and NA-A to with dressing, providing ing his hair, and putting on the observation.  In sof R69 on 1/13/16, at 4/16, at 9:10 a.m., the inshaven.  1/13/15, at 8:16 a.m. NA-A pleted with cares for R69, are or shaving was completed ident. NA-A stated R69 was cares and shaving  1/14/16, at 9:10 a.m. R69 the instance of t	F	311				

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245517	B. WNG	<u></u>	01/14/2016
NAME OF PROVIDER OR SUPPLIER  OAKLAWN CARE & REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		1	STREET ADDRESS, CITY, STATE, ZIP CODE  RO1 OAKLAWN AVENUE  WANKATO, MN 68001  PROVIDER'S PLAN OF CORRECTION	(×6)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 311	every day on males.  During Interview on 1, stated oral cares were with cares in the morn shaving was to be offi. R69's care plan indica grooming and oral care offering and providing cares.  Review of the facility's Standards of Practice "Dentures in at mornin oral care in the mornin day. 25(h) FREE OF A HAZARDS/SUPERVITHE facility must ensue environment remains as is possible; and ea adequate supervision prevent accidents.  This REQUIREMENT by: Based on observation review, the facility fail residents (R128 and I assessed for safe use (4WW), with the walk manner consistent with the state of the s	ving was to be completed  /14/16, at 11:10 a.m. RN-B e expected to be completed hing and at bedtime, and ered daily. RN-B stated ated assist of one staff for res, and staff should be assistance with all personal a undated policy titled Routine Care included, ng and out at bedtime. Give ng and at bedtime."  ACCIDENT SION/DEVICES  are that the resident as free of accident hazards on resident receives and assistance devices to  is not met as evidenced  n, interview, and document ed to ensure 2 of 2 R66) were appropriately of a four-wheeled walker ers being utilized in a th the manufacturer's	F 311	1. R128 has discharged from facility 2. R66 plan of care will be updated ambulation; resident will ambulate wone assist with wheelchair behind in 3. Education will be provided to start proper transportation with 4 wheel was Also, education to staff to notify maintenance director or housekeep director if noted a concern with resident equipment, including 4WW.  4. Staff will review and sign off on proper/competency of use of 4 wheels.	for with esident. if on walker.  ing dent  el audit et safety nue ually aluated erstand iill be
	recommendations, and remaining in solution order with properly functioning brakes	•		8. Facility will be compliance by February 23rd, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/8UPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245517	B. WNG		01.	/14/2016
	ROVIDER OR SUPPLIER	ION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 58001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 323	diagnoses including of with cochlear implant R128's admission Mir dated 12/29/15, identiseverely impaired and for most activitias of of R128's Care Area Assistance from one abelt and walker, for training the CAA noted R128 secondary to her cognistaff to provide ongoir obtain assistance with her physical therapist mobility. The CAA als received occupational The PT Daily Treatmer R128 had good balant.	port dated 1/13/16, identified elementia and hearing loss status.  Immum Data Set (MDS) ified R128's cognition was drequired limited assistance laily living (ADLs).  Ressment (CAA) dated 8 required limited staff with the use of a gait ansfers and ambulation.	F 323			
	environment. The no- Instructed on the use directed to begin usin from one staff for cue- corresponding PT and dated 1/6/16, directed R128, with assistance transfers and to/from	te indicated R128 was of a 4WW and nursing was g the 4WW, with assistance s with directions. The d OT communication Note I nursing to use a 4WW for from one staff for all the bathroom.  d 1/12/16, directed staff to the potential need for				

STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	TIPLE CONSTRUCTION		re survey MPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBERS	A. BUILDI	ŅG		
r		245617	B, WING			1/14/2016
	ROVIDER OR SUPPLIER	ION CENTER		STREET ADDRESS, CITY, STATE, ZIP 201 OAKLAWN AVENUE MANKATO, MN 56001	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	to her cognitive impa plan indicated, "[R12 forgetfulness, altered walk with her at all tir impairment and coch plan instructed, "Ensithat [R128] needs is functional (glasses, horasfer and ambula [one], gait belt and wardditional care plant providing R128 with self-transfer, assistin redirection, ensuring place, reproaching the and documenting on During observation of 1/11/16, at 5:20 p.m. independently with the approximately 50 fee nursing staff were protection, and sat on the seat applying the brakes, to roll backward abordown. After her butt walker continued to foot, with her feet ex She then stood up frapply the breaks to all rolled back slightly a down. R128 made is stand with the walker eaching a standing	s, risks, and needs in relation irment and safety. The care is has confusion and it mobility (needs someone to mes), has a severe hearing lear implant" The care ure that adaptive equipment provided and is present and hearing aid, walker) the with timited assist of 1 malker or per PT instructions." and interventions included reminders not to go her with reorientation and her hearing device was in the reas needed, and monitoring her safety.	F	323		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

94111411	S FOR MEDICARE &	MEDICAID SERVICES			(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING		GOMPLETED
		246617	B. WING		01/14/2016
	ROVIDER OR SUPPLIER	ION CENTER	20	REET ADDRESS, CITY, STATE, ZIP CODE 1 OAKLAWN AVENUE ANKATO, MN 56001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOÙI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 323	dining room, approad walk with her back to around to face the w steady herself as shifthe dining room using assistance by the N/During observation of registered nurse (RN tolleting, RN-B apply she was in a seated room, RN-B placed and set the bilateral from the bed with stipegan to walk with the brakes. RN-B strontinued walking wwalker. R128's heat the time of this of the right brake as R motion and prompte as she held the 4W walking with her to the brake remained in proll with ease. Thro to her bed, R128 coapply or disengage R128 dld not apply 4WW at any point of During interview on 7:55 a.m. NA-E conprimary steff, and applying/ releasing prompted by staff, a device in.	ched R128 and offered to her room. R128 turned alker, requiring the walker to e turned, and R128 then left g her 4WW receiving	F 323		

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245817	B. WNG			01/	14/2016
	ROVIDER OR SUPPLIER	ION CENTER	·	2	TREET ADDRESS, CITY, STATE, ZIP CODE 01 OAKLAWN AVENUE MANKATO, MN 58001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 323	regarding R128's use cognition and physical factors used in determ was most appropriate for a 4WW they asses could comprehend he walker, and whether i judgement/ awareness appropriate to do so, above observations of PT-A stated R128 had been assistance from one and the stated R128 had been assistance from one and the stated R128's amplifier (he appropriately, she did prompts and used the During observation of went into R128's room therapy session. R12 the day, so PT-B beg R128 to complete he sat at the side of her amplifier/ hearing devithen placed the 4WW the entire observation apply or disengage the prompted to do so. In through use of the balanchair at the dining room the di	e of the 4WW. PT-A stated al ability were some of the mining which type of walker of or a resident, and stated seed whether a resident the teresident had the set to know when it was once informed of the of R128's use of the 4WW, ay require a re-evaluation to lith the use of a 4WW. PT-B in assessed to be provided staff when using the 4WW, incly worked with R128, and and impulsivity, R128 one staff and should always provide prompting and se of the 4WW, PT-B stated earing device) was applied a well with following staff a 4WW appropriately.  In 1/13/16, at 8.53 a.m. PT-B in to complete the residents 28 had not yet dressed for an to provide assistance to remorning cares. As R128 bed, PT-B applied her wice, applied a gait belt, and win front of her. Throughout in of cares, R128 did not the brakes of the 4WW until PT-B provided this prompting athroom, dressing, grooming, ing room, and sitting in her om table. PT-B stated it was quire this level of prompting	F	323			

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		SURVEY
		246517	B. WNG		01/14/2016	
	ROVIDER OR SUPPLIER  N CARE & REHABILITAT	ION CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 101 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 323	observation, the left find again noted to continue being engaged.  During observation or and NA-D provided stone of a gait belt and 4VV back to her room. Rapprompts for locking at the 4VWV, but was conformed to left brait working, and while the walker rolled forwimmediately stated shimaintenance and havinght away.  On 1/14/16, at 9:22 a seated in the facility's walker placed next to observed in the PT roused on the PT made a chapt was concerned with walker and, "She [R12] like sitting on it and put and walking, when pher." NA-E stated she this in the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the past, and significant and re-eduction of the PT was concerned with the PT was	ront wheel of the 4WW was ue rolling, despite the brake an 1/13/18, at 9:26 a.m. NA-C and-by assist with the use W while R128 ambulated 28 again required constant and unlocking the brakes to impliant with following those and to the therapy room. PT-B are of R128's 4WW was not a left brake was engaged, and and backward. PT-B are would inform a them repair the brake are them repair the brake and the 4WW was om.  1/14/16, at 9:35 a.m. NA-E ange to R128's walker, and the her unsafe use of the 28] had developed a habit of ushing herself backwards utiling it [the 4WW] behind a had observed R128 doing the had attempted to eate R128 on the safe use of the observed this. NA-E are left brake to the 4WW was	F 323			

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245517	B. WNG			01/	14/2016
	ROVIDER OR SUPPLIER	ION CENTER		201	REET ADDRESS, CITY, STATE, ZIP CODE 1 OAKLAWN AVENUE ANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .8C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROBS-REFERENCED TO THE APPROPRIA DEFICIENCY)	: TE	(X5) COMPLETION DATE
F 323	During interview on 1 stated she had seen I self-transfer attempts self-transfer and self-However, RN-B state was using her 4WW I left-front brake was now RN-B stated there was evaluate maintenance however, if staff notic resident equipment, it maintence immediate R66's Order Summar identified diagnoses i disease, atrial fibrillat osteoporosis.  R66's quarterly MDS R66 had moderately independent with most atabilize herself without CAA identified R66 wo f a wheeled walker independent with ADI ambulation, but direct assistance as needed identified R66 demonon exertion and was and staff was directed.	A noted R66 was unstable and tage and and cognition and was st ADLs.  A noted R66 was unstable and assistance. The assindependent with the use for transfers and ambulation.  A 1/12/16, noted R66 was Ls, transfers, and increased respirations, and increased respirations, and increased respirations, and astrated shortness of breath currently oxygen dependent, and increased respirations, and astrated shortness of breath currently oxygen dependent, and increased respirations, and increased respirations.	F	323			

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

245517 B. WING	0.45545		
245517   B. WING   01/14/2	245517		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  201 OAKLAWN AVENUE  MANKATO, MN 86001			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROMDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	EOED BY FULL	(EACH DEFICIENCY	PREFIX
F 323  Continued From page 16  During observation on 1/11/16, at 6:49 p.m. RN-A was observed propelling R66 from the dining room area, down the mein heliway of the facility, to the nurse's station in the South wing. R66 was observed seated on the bench of her 4WW, while RN-A pushed her down the hallway. Once at the nurse's station, RN-C checked R86's oxygen saturation and stated the saturation was low and she needed to administer her oxygen. RN-C proseded to propel the walker down the Southeast hallway to her resident room, while R68 remained seated on the bench of the 4WW,  During interview on 1/11/16, at 6:33 p.m. R86 stated facility staff routinely pushed her white she sat on the bench of her 4WW.  During interview on 1/13/16, at 6:35 a.m. PT-A stated it was not a safe practice to propel a 4WW while a realdent was seated on the bench, and stated all facility staff should know this was not an acceptable way to transport a resident.  During interview on 1/14/16, at 6:51 a.m. RN-A stated she had never transported R86 by propelling her on the 4WW in the past, however, she felt there was some urgency to transport R86 to the nurse's station as she had reported shoulder pain and required immediate assessment. RN-A stated she was aware transporting a resident in this manner was not appropriate and stated the facility had wheelchairs available in the facility for scenarios like this.  During interview on 1/14/16, at 1:56 p.m. RN-B (R86's care manager) stated R66 had her own wheelchair which was used for some outlings or longer distences, and the wheelchair was kept in	the dining of the facility, wing. R66 was ser 4WW, while y. Once at the d's oxygen n was low and en. RN-C wn the room, while n of the 4WW. d p.m. R66 I her while she fa.m. PT-A propel a 4WW bench, and this was not an itent.  1 a.m. RN-A R66 by last, however, of transport R66 eported iate s aware her was not had for scenarios  6 p.m. RN-B had her own he outings or	During observation on was observed propelling noom area, down the mito the nurse's station in observed seated on the RN-A pushed her down nurse's station, RN-C construction and stated it she needed to administ proceeded to propel the Southeast hallway to here are always to here. During interview on 1/1 stated facility staff routing are stated at a facility staff seated	F 323

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

_CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO, 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		re survey MPLETED
		245517	B. WING		0.	1/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	N CARE & REHABILITAT	ION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	during the day shift or to the dining room with became tired. The ad approached R66 and her walker bench for noted to state, "Push push me up to the tak AD proceeded with puremained seated on to During interview on 1, confirmed she was avento transport residents	in, Direction, or gned 1/14/16, indicated in 1/12/16, R66 was walking in her 4VWW when she citylty director (AD) encouraged her to sit on a period to rest. R66 was me up to the table Just ble we are almost there."	F3	23		
	for the Rollater 4VVW instructions) dated 8// individual should ALM physician or therapist adjustment and usage as a wheelchair or tranot intended to be probrakes MUST be in the using the seat. A phy should assist in the herollator for maximum activation When usi stationary position, the locked" The instructure and maintenance operation of the brake necessary Inspect v	IO, directed, "Each IAYS consult with their to determine proper a. DO NOT use the rollator insport device. Rollators are ipelled while seated. The ise locked position before sloal/occupational therapist eight adjustment of the support and correct brake ing the rollator in a ise hand brakes MUST be tions also directed routine is, including, "Verify is and have them adjusted if wheels periodically for wear any broken, damaged or				

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		245517	B, WING			01.	1412016
	ROVIDER OR SUPPLIER	TION CENTER	- <b>,</b>	20	REET ADDRESS, CITY, STATE, ZIP CODE M OAKLAWN AVENUE ANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC (DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	85	(X5) COMPLETION DATE
F 441 SS=F	SPREAD, LINENS  The facility must esta Infection Control Prosafe, sanitary and coto help prevent the dof disease and infection Control The facility must esta Program under which (1) Investigates, continuithe facility; (2) Decides what proshould be applied to (3) Maintains a recording related to infection of the facility when the Infection determines that a respreyent the spread of isolate the resident. (2) The facility must communicable disease from direct contact will trace (3) The facility must hands after each direct contact will trace (4) The facility must hands after each direct contact will trace (5) Linens Personnel must hands	Program ablish an Infection Control in it - irols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections.  d of Infection in Control Program sident needs isolation to f infection, the facility must crohibit employees with a se or Infected skin lesions ith residents or their food, if insmit the disease, require staff to wash their ect resident contact for which cated by accepted	F	441	1. All residents currently residing facility have been reviewed for integration of the complete day of the	ections. s are  ary Team. bus Qualit atistic form rs s, or ns. m to track will assis o other  led be onthly	<b>b</b> .

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		SURVEY PLETED
		245617	B. WING		01	/14/2016
	ROVIDER OR SUPPLIER	ION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 441	This REQUIREMENT by: Based on interview a facility failed to impler program that included resident infections whitending resident name signs and symptoms identified microorgani of resolution of infecti affect all 69 residents facility.  Findings include: The facility's infection from July 2015, through facility utilized a form improvement, Monthly Statistics. The form ic such as urinary tract (lower respiratory, gas nose and mouth, systems of infections; and next to the type of infections; and included, "Carried Over Rate." The infections category.  A review of the Continum Monthly Resident Infections, which included infections, which included infections, which included catheter related infections.	is not met as evidenced and document review, the ment an infection control it ongoing surveillance of alch included tracking and ale and location in the facility, of infections, date of onset, sm, treatment, and/or date on. This had the potential to currently residing in the  control logs were reviewed gh December 2015. The titled Continuous Quality y Resident Infection lentified types of infection (UTI), upper respiratory, strointestinal, skin, eye, ear, temic, unexplained febrile bus) site, vaginal, and other d tally marks were made ection, and identified as, al acquired]" or "Socomial Other columns identified ter," "Total," "Resolved," and the were tallied according to  muous Quality Improvement, ection Statistics form for located there were 18	F 4	41		

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

	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		248517	B. WNG			01/	14/2016
	ROVIDER OR SUPPLIER	ION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 1 OAKLAWN AVENUE ANKATO, MN 58001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E Ate	(X5) COMPLETION DATE
F 441	These were tallied ur column. The Quality area on the form was did not include identificating of resident's and symptoms, date microorganism, treation tracking, or summarismicroorganisms to lid.  A review of the Contification of the Contifi	wo other sites of infection. Ider the, "Nosocomial" Improvement Conclusion Iblank. The documentation Ication of the resident, Iocation in the facility, signs of onset, identified Interest of congoing surveillance, Icing of infections or Interest of cate of resolution. Incous Quality Improvement, Incous Quality Infections. The I Listing Report, which was It in November 2015, on the Incouse Infection on the Incouse Infection Interest of UTI, and on the Incouse Infection Interest of UTI, and on the Incouse Infection Interest of UTI's, Indicated Interest of UTI's, Inte	F	441			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEPOLIPORISS  NOP PLAN OF CORRECTION  245677  NAME OF PROVIDER OR SUPPLIER  COALLAWAY CARE & REHABILITATION CENTER  CANALAWAY CARE & REHABILITATION CENTER  DISTRIBUTION  SUMMARY STATEMENT OF DEFICIENCIES (GRAN DEPICIENCY MUST BE PRECUEDED BY FULL)  FINANCY TAG  F. 441  Continued From page 21  which included the residents name, name of artibiotic, and the data started. However, this information was not tracked with the actual infection program, and there was no documentation which included any monthly summary of infections and of trends (dentilied.  The facility policy dated 9/24/16, titled Infection control runs deep survivalence of Noscomial and Socomial infections by. "Review of culture reports and other performent be desta. Nurse consultation and referral. Chart review. Review of Infection communication form? Physician Orders. Personal consultation of employees. Follow-up on communication form? Physician Orders. Personal consultation of employees. Follow-up on communication form? Physician on survival properties and other performance of the employees. Follow-up on communication form? Physician consultation."	CENTER	S FOR MEDICARE &	WEDICAID SERVICES				040) 5455	CUDVEY
NAME OF PROVIDER OR SUPPLIER  OAKLAWN CARE & REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 441  Continued From page 21 which included the residents name, name of antibiotic, and the date started. However, this information was not tracked with the actual infection program, and there was no documentation which included any monthly summary of infections and/ or trends identified.  The facility policy dated 9/24/15, tilled Infection Control nurse does surveillance of Nosocomial and Socomial infections by: "Review of culture reports and other pertinent lab date. Nurse consultation and referral. Chart review. Review of Infection communication form/ Physician Orders. Personal consultation of employees. Follow- up on communicable disease exposure. Antibiotic monitoring. Malintenance of the employee health statistics records. Physician			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		•		
NAME OF PROVIDER OR SUPPLIER  OAKLAWN CARE & REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FACTOR Which included the residents name, name of antibiotic, and the date started. However, this information was not tracked with the actual infection program, and there was no documentation which included any monthly summary of infections and/or trends identified.  The facility policy dated 9/24/15, titled Infection Control Surveillance of Nosocomial and Socomial infections by: "Review of culture reports and other pertinent lab date. Nurse consultation and referral. Chart review. Review of Infection communication form/ Physician Orders. Personal consultation of employees. Follow-up on communication form/ Physician Orders. Personal consultations of the employee health statistics records. Physician			245517	B. WING			01/	14/2016
SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION SHOULD SE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD SE (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY)   CONTINUED TO THE APPROPRIATE DEFICIENCY)   DEFICIENCY    F 441   Continued From page 21   Which included the residents name, name of antibiotic, and the date sterted. However, this information was not tracked with the actual infection program, and there was no documentation which included any monthly summary of infections and/ or trends identified.  The facility policy dated 9/24/15, titled infection control nurse does surveillance of Nosocomial and Socomial infections by: "Review of culture reports and other pertinent lab data. Nurse consultation and referral. Chart review. Review of Infection communication form/ Physician Orders. Personal consultation of employees. Follow- up on communicable disease exposure. Antibiotic monitoring. Maintenance of the employee health statistics records. Physician	OAKLAWN CARE & REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 441 Continued From page 21 which included the residents name, name of antibiotic, and the date started. However, this information was not tracked with the actual infection program, and there was no documentation which included any monthly summary of infections and/ or trends identified.  The facility policy dated 9/24/15, titled Infection Control Surveillance indicated the infection control nurse does surveillance of Nosocomial and Socomial Infections by: "Review of culture reports and other pertinent lab data. Nurse consultation and referral. Chart review. Review of Infection communication form/ Physician Orders. Personal consultation of employees. Follow- up on communicable disease exposure. Antibiotic monitoring. Maintenance of the employee health statistics records.		201	OAKLAWN AVENUE .				
which included the residents name, name of antibiotic, and the date started. However, this information was not tracked with the actual infection program, and there was no documentation which included any monthly summary of infections and/ or trends identified.  The facility policy dated 9/24/15, titled Infection Control Surveillance indicated the infection control nurse does surveillance of Nosocomial and Socomial Infections by: "Review of culture reports and other pertinent lab data. Nurse consultation and referral. Chart review. Review of Infection communication form/ Physician Orders. Personal consultation of employees. Follow- up on communicable disease exposure. Antibiotic monitoring. Maintenance of the employee health statistics records. Physician	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	85	COMPLETION
	F 441	which included the reantibiotic, and the da information was not to infection program, and documentation which summary of infection.  The facility policy day Control Surveillance control nurse does and Socomfal infection reports and other perconsultation and refer of Infection commun. Orders. Personal confollow- up on commun. Antibiotic monitoring employee health sta	esidents name, name of the started. However, this tracked with the actual and there was no included any monthly as and/ or trends identified.  The design of the infection indicated the infection urveillance of Nosocomial ons by: "Review of culture rtinent lab data. Nurse arral. Chart review. Review ication form/ Physician insultation of employees. unicable disease exposure.  Maintenance of the	F	441			

Minnesot	a Department of Healt	h				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:	1	33""	
			D 11010			4410040
		00038	B. WING		1 072	14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
OAKI AWI	N CARE & REHABILITAT	TON CENTER 201 OAKL	AWN AVENUE			
DANCAL	TOAKE & REHADIENA	MANKATO	, MN 56001			
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID ID	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION		(X8) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH	E APPROPRIATE	DATE
				DEFICIENCY	)	
2 000	Initial Comments		2 000			
	TIME COMMICING					
	*****ATTEN	ITION*****				
		·				
	NH LICENSING C	ORRECTION ORDER				
	In accordance with M	linnesota Statute, section				
		ion order has been issued				
	pursuant to a survey	If, upon reinspection, it is				
		ncy or deficiencies cited				
		ted, a fine for each violation e assessed in accordance				
		es promulgated by rule of				
	the Minnesota Depar					
	.,	ether a violation has been				
	corrected requires co	ompliance with all rule provided at the tag				
		and provided at the tag e number indicated below.				
		s several items, fallure to				
		ne items will be considered				
		Lack of compliance upon				
		y item of multi-part rule will tent of a fine even if the item				
		ing the Initial Inspection was				
	corrected.					
			,			
		earing on any assessments				
		non-compliance with these a written request is made to				
		in 15 days of receipt of a			`\	
		t for non-compliance.		// ,		\
	DUTAL COLUMNIA	<b>.</b> .			$\mathcal{W}$	
	INITIAL COMMENTS	s: 016, aurveyors of this			(	
		visited the above provider and			( )	
		ion orders were issued.			MARINA	
		e completed, please sign and		1/ / //	1/1/Dr 1/	
		f these orders and return the sota Department of Health,		///	11 N 11 1/1	
		ce Monitoring, Licensing and			$\mathcal{L} \mathcal{H} \mathcal{L}$	<i>x</i> I
Managara - Inc	<u> </u>	an maintaining manning and			W 11/	
	parlment of Health DIBECTOR'S OR PROVIDER	ISUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
114				Adminis	how the	2/15/1/
STATE FORM	1		6599			ualish sheet 1 of 15
			,			

Oaklawn Care & Rehabilitation Center January 27, 2016 Page 2

Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division #212, St. Cloud MN, 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WNG 00038 01/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **201 OAKLAWN AVENUE OAKLAWN CARE & REHABILITATION CENTER** MANKATO, MN 56001 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) 2 000 Continued From page 1 2 000 Certification Program, 3333 West Division St. Suite 212, St Cloud, MN 56301. 2 565 MN Rule 4658.0405 Subp. 3 Comprehensive 2 565 Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced Based on observation, interview, and record review, the facility failed to provide cares according to the resident's written plan of care for 2 of 4 residents (R37, R69) reviewed for activities of dally living (ADLs). Findings include: R37's diagnosis noted on the admission record dated 6/9/11, included osteoarthritis, anxiety disorder, and cognitive decline. R37's significant change Minimum Data Set (MDS) dated 11/25/15, Indicated R37 had moderate cognitive impairment, and required extensive assistance of one staff for dressing and personal hygiene. R37's care plan, dated 12/3/15, indicated R37 had oral/dental health problems related to multiple missing teeth, and had a full upper denture, and a lower partial. Interventions included, "Provide set up assist as needed for oral cares. He is able to brush his own teeth."

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: 01/14/2016 00038 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE **OAKLAWN CARE & REHABILITATION CENTER** MANKATO, MN 56001 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) 2 565 2 565 Continued From page 2 During observation and interview on 1/11/16, at 5:53 p.m. R37 was observed with no upper teeth, and had a few natural teeth on the front bottom which were covered with a whitish substance. R37 stated he hadn't brushed his teeth in, "Along time," and he didn't always wear his top plate because it didn't fit well and would fall out when he drank cold liquids. On 1/12/16, at 4:10 p.m. R37's bottom natural teeth were again observed to be covered with a whitish matter and dark particles, and he had no denture or partial in his mouth. During observation on 1/13/16, at 7:34 a.m. R37 was sitting on the toilet while nursing assistant (NA)-F performed personal care. NA-F transferred R37 from the toilet to his wheelchair with a mechanical lift, and pushed R37 out of the room into the common area of the North wing for breakfast. Although NA-F stated she was finished assisting R37 with his morning cares, R37 was not offered oral cares during the observation. When interviewed on 1/13/16, at 8:20 a.m. NA-F stated R37's dentures were usually brushed at night and then she assisted the resident to put the dentures in the morning, morning, NA-F stated she did not put in R37's dentures, and went and asked the resident if he wanted to put his teeth in and R37 replied, "Well, why not?" NA-F pushed R37 back into his bathroom, brushed his bottom partial, applied denture adhesive, and placed it in his mouth. NA-F searched the cabinet for R37's top denture and stated she did not think R37 had any top dentures. NA-F stated she needed to ask for assistance in finding R37's top denture, and left the room, While NA-F was gone, R37 asked, "Am I going to get to scrub my teeth today?" NA-F

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		00038	B. WNG		01	<u> 14/2018</u>
ME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE		
AKLAWI	N CARE & REHABILITAT	ION CENTER	(LAWN AVENUE TO, MN 56001			
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2 586	both began looking in denture and it was loo slowly picked up his tapplied toothpaste witto brush his bottom not the bathroom and it brushing. NA-F brush denture adhesive, an R37's mouth. NA-F parea of the North wind table for breakfast. Ratio his teeth in and states since he had them in Review of the Oral/Dr. 11/20/15, included R. full denture, and lowers several missing teeth poor oral hygiene, and to remind/cue him to [as needed]. Resident teeth with set up."  During interview on 1 registered nurse (RN refused oral cares and fhis mouth, however and encouraging oral residents plan of care.  R69's quarterly MDS the resident had seve diagnosis including drequired extensive as hygiene including brushing incl	room with NA-G and they R37's room for his top cated in R37's room. R37 oothbrush from the sink, th some difficulty, and began atural teeth. NA-F returned assisted R37 to finish sed the top denture, applied diplaced the denture in ushed R37 into the common g, and placed him at the 37 stated it felt good to have dit had been a long time.  The partial denture, and had a brand new upper are partial denture, and had die summary noted, "Staff do oral cares and assist print it is able to brush his own.  113/16, at 2:26 p.m.  1-D stated R37 occasionally did often took his dentures out are, staff should be offering it cares dally according to the second of the	2 565			
	resident required ass	d 11/6/15, directed staff				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, STA	ATE, ZIP CODE	
OAKLAWI	N CARE & REHABILITAT	ION CENTER	AWN AVENUE ), MN 56001		
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2 565	Continued From page	4	2 565		
	assist with washing fa	and to set up resident to ace and hands and brushing assistance with oral cares d as needed.		·	
	at 7:54 a.m. NA-A ass R69 was able to wash after being provided v assisted the resident perineal care, combin	morning cares on 1/13/18, sisted R69 to the bathroom. In his face independently with the washcloth, and NA-A with dressing, providing g his hair, and putting on was provided or offered to vation.			
	stated she was compl and stated no oral car	113/15, at 8:16 a.m. NA-A leted with cares for R69, re was completed or offered A-A stated she believed orm oral cares			
	stated he liked to brus	/14/16, at 9:10 a.m. R69 sh his teeth when he gets up ver, he was not sure if staff shing his teeth.			
		/14/16, at 9:15 a.m. RN-A e to be provided twice per sistants.			
	stated oral cares were	1/14/16, at 9:23 a.m. NA-B e to be provided and/ or d should offer assistance or		·	·
	stated oral cares were with cares in the morr R69's care plan indica	14/16, at 11:10 a.m. RN-B e expected to be completed along and at bedtime, and ated assist of one staff for res, and staff should be			

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: B. WING 00038 01/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE **OAKLAWN CARE & REHABILITATION CENTER** MANKATO, MN 56001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 2 565 Continued From page 5 2 565 offering and providing assistance with oral cares according to the residents plan of care. Review of the facility's undated policy titled Standards of Practice Routine Care included, "Dentures in at morning and out at bedtime. Give oral care in the morning and at bedtime." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could in-service all staff to follow care plans in regards to specific resident cares and services and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days. 2 915 MN Rule 4658.0525 Subp. 6 A Rehab - ADLs 2 9 1 5 Subp. 6. Activities of dally living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the tailet; (4) eat; and (5) use speech, language, or other functional communication systems; and

Minnesota Department of Health

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STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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2 915	Continued From page	6	2 915			
	by: Based on observation review, the facility fall with grooming for 2 of required staff assistant Findings include: R37's diagnosis noted dated 6/9/11, included disorder, and cognitive R37's significant char (MDS) dated 11/25/15 moderate cognitive in extensive assistance personal hygiene. R37's care plan, updahad oral/dental health multiple missing teeth denture and a lower pincluded, "Provide set oral cares. He is able During observation ar 5:53 p.m. R37 was obtained and a few natural which were covered writine," and he didn't all because it didn't fit we he drank cold liquids.	ige Minimum Data Set 5, Indicated R37 had apairment, and required of one staff for dressing and ated 12/3/15, indicated R37 problems related to , and had a full upper				
		vhitish matter and dark no denture or partial in his				

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AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	1		COMPLI	ETED
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AUMPONI	ONNE & REPROPERTY	MANKATO	, MN 56001			
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2 915	Continued From page	97	2 915			
	During observation or	n 1/13/16, at 7:34 a.m. R37				
		et while nursing assistant				
	(NA)-F performed per					
	transferred R37 from	the toilet to his wheelchair				
		and pushed R37 out of the				
		n area of the North wing for				
		IA-F stated she was finished				
		morning cares, R37 was				
	not offered oral cares	during the observation.				
	180 1-4	4140140 -1 0.00 - No. 314 E	-	,		
		1/13/16, at 8:20 a.m. NA-F				
		s were usually brushed at		, i		
		sisted the resident to put orning. morning. NA-F				
		member if she helped him				
		, and walked over to R37				
		were not in. NA-F asked				
		out his teeth in and R37				
		t?" NA-F pushed R37 back				
		ushed his bottom partial,				
		sive, and placed it in his				
		ed the cabinet for R37's top				
		ne did not think R37 had any				
	top dentures. NA-F o					
	assistant care sheet (	(which directs staff on		*		
		tated, "It says he has upper				
		" When she could not locate				
		A-F stated she needed to				
		nd left the room. While NA-F				
		d, "Am I going to get to scrub				
		-F came back into R37's				
		they both began looking in				
		p denture. R37 slowly picked				
	up his toothbrush from					
		difficulty, and began to				
		ural teeth. NA-F located	1			
		the residents room, returned				
		assisted R37 to finish sed the top denture, applied				
	i drusning. NA-F hrust	ied toe top denture. Applied	1	İ		

Minnesota Department of Health STATE FORM

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 915	Continued From page	8	2 915		
	R37's mouth. NA-F the common area of the table for breakf to have his teeth in ar time since he had the Review of dental hygi	ene progress notes from the			
	Minneapolis Veteran's 5/11/15, Indicated R3: calculus and heavier of throughout the remain "Personal Oral Hygier	s Administration dated  7 had moderate amounts of amounts of plaque found sing teeth. Also included, he: poor. Patient needs to a longer amount of time.			
	full denture, and lower several missing teeth. poor oral hygiene, and to remind/cue him to o	ental Evaluation dated 7 had a brand new upper r partial denture, and had Also included, R37 had d the summary noted, "Staff do oral cares and assist prn is able to brush his own			
	refused oral cares and	-D stated R37 occasionally d often took his dentures out , staff should be offering			
	the resident had sever diagnosis including de required extensive ass hygiene including brus	dated 10/28/15, identified re cognitive impairment had smentia and anxiety, and sist of one staff for personal shing his teeth and shaving.	·		
	resident required assis	11/6/15, directed staff that at of one with grooming nd to set up resident to			

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION (DENTIFICATION NUMBER: COMPLETED A. BUILDING: 00038 B. WNB 01/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **201 OAKLAWN AVENUE OAKLAWN CARE & REHABILITATION CENTER** MANKATO, MN 56001 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE DATE ſD PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 2 915 | Continued From page 9 2915 assist with washing face and hands and brushing teeth, and to provide assistance with oral cares morning, bedtime, and as needed. During observation on 1/12/16, at 9:56 a.m. R69 was in his room, unshaven, with hair along his cheeks approximately four millimeters (mm) in length, and chin hair approximately two mm. On 1/12/16, at 3:39 p.m. R69 was observed in the dayroom, watching television and remained unshaven. During observation of morning cares on 1/13/16, at 7:54 a.m. NA-A assisted R69 to the bathroom. R69 was able to wash his face independently after being provided with the washcloth, and NA-A assisted the resident with dressing, providing perineal care, combing his hair, and putting on glasses. No oral care or shaving was provided or offered to R69 during the observation. Additional observations of R69 on 1/13/16, at 11:08 a.m., and 1/14/16, at 9:10 a.m., the resident remained unshaven. During Interview on 1/13/15, at 8:16 a.m. NA-A stated she was completed with cares for R69, and stated no oral care or shaving was completed or offered to the resident. NA-A stated R69 was able to perform oral cares and shaving independently. During interview on 1/14/16, at 9:10 a.m. R69 stated he liked to brush his teeth when he gets up in the morning, however, he was not sure if staff assisted him with shaving or brushing his teeth. During interview on 1/14/16, at 9:15 a.m. RN-A stated oral cares were to be provided twice per

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL	
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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2 915	Continued From page	10	2 915			
	day by the nursing as	sistants.				
	stated oral cares were offered every day, and	1/14/16, at 9:23 a.m. NA-B e to be provided and/ or d should offer assistance or ving was to be completed				
,	stated oral cares were with cares in the morr shaving was to be off R69's care plan indice grooming and oral ca	/14/16, at 11:10 a.m. RN-B e expected to be completed ning and at bedtime, and ered daily. RN-B stated ated assist of one staff for res, and staff should be assistance with all personal		,		
		Routine Care included, ng and out at bedtime. Give				
	director of nursing an or revise policies, and regarding resident gro Assessment and Asse	OD OF CORRECTION: The d/or designee could review of provide education for staff coming. The Quality urance (QAA) committee its to ensure compliance.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21390	MN Rule 4658.0800 5	Subp. 4 A-I Infection Control	21390			
	control program must procedures which pro	d procedures. The infection include policies and ovide for the following: ased on systematic data				

Minnesota Department of Health STATE FORM

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
OAKLAWI	N CARE & REHABILITAT	ION CENTER 201 OA	KLAWN AVENUE			
		MANKA	TO, MN 56001			
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21390	Continued From page	11	21390			
	collection to identify in residents;  B. a system for dicentrol of outbreaks of C. isolation and preduce risk of transmit D. in-service educe prevention and control of outbreaks of the collection of the collection of the collection of the prevention and control of the prevention and treating the development of	etection, investigation, and infectious diseases; precautions systems to ssion of infectious agents; cation in infection of infection in infection of infection of infection of infection of infections; and policies and ot care practices to assist in pattern of infections; and infection control tuberculosis program as infection control tuberculosis program as infection control tuberculosis program as infection of infection of infection control of infection control, such as ics, gloves, and				
	Findings Include:					

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WNG 00038 01/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **201 OAKLAWN AVENUE OAKLAWN CARE & REHABILITATION CENTER** MANKATO, MN 56001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21390 Continued From page 12 21390 The facility's infection control logs were reviewed from July 2015, through December 2015. The facility utilized a form titled Continuous Quality Improvement, Monthly Resident Infection Statistics. The form identified types of infection such as urinary tract (UTI), upper respiratory. lower respiratory, gastrointestinal, skin, eye, ear, nose and mouth, systemic, unexplained febrile episode, IV (intravenous) site, vaginal, and other sites of infections; and tally marks were made next to the type of infection, and identified as, "Nosocomial, [hospital acquired]" or "Socomial [acquired in facility]." Other columns identified included, "Carried Over," "Total," "Resolved," and "Rate," The Infections were tallied according to category. A review of the Continuous Quality Improvement, Monthly Resident Infection Statistics form for September 2015, indicated there were 18 Infections, which included four urinary tract non-catheter related infections, one urinary tract catheter related infection, five lower respiratory infections, one gastrointestinal tract infection, five skin infections, and two other sites of infection. These were tallied under the, "Nosocomial" column. The Quality Improvement Conclusion area on the form was blank. The documentation did not include identification of the resident, tracking of resident's location in the facility, signs and symptoms, date of onset, identified microorganism, treatment, or date of resolution. There was no evidence of ongoing surveillance, tracking, or summarizing of infections or microorganisms to identify if there was a pattern. A review of the Continuous Quality Improvement, Monthly Resident Infection Statistics form for November 2015, indicated there were 8 UTI's

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21390	identified as "Nosocol corresponding Order in the monthly antibiotic pharmacist, identified South East Wing, 3 reantiblotics for UTI, on were treated with antil South West Wing, one UTI. Although the Comprovement, Monthly Statistics form for Now there were 8 resident corresponding docum which residents were where they were locat microorganism was, a effective.  During interview on 17 registered nurse (RN) of the facility infection nurse managers met a discussed resident infinanciate ran month which included the resentibiotic, and the date information was not trainfection program, and documentation which is summary of infections  The facility policy date Control Surveillance in control nurse does sur and Socomial infectior reports and other pertitores.	mial" infections. The Listing Report, which was use report run by the in November 2015, on the esidents were treated with the North Wing, 2 residents biotics for UTI, and on the estedent was treated for intinuous Quality / Resident Infection rember 2015, indicated UTI's, there was no entation which Indicated being tracked for UTI's, ed in the facility, what the nd if the antibiotic was  13/16, at 1:30 p.mE, who was also in charge control program, stated the every morning and ections. RN-E stated the by antibiotic use reports idents name, name of estarted. However, this eacked with the actual I there was no included any monthly and/ or trends identified.  d 9/24/15, titled infection recillance of Nosocomial as by: "Review of culture nent lab data. Nurse	21390	DEFICIENCY)	
	consultation and referr of Infection communications. Personal con-	al. Chart review. Review		·	

Minnesot	a Department of Healt	h				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SUI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		2000	B. WNG	·	01/14	12016
		00038			1 411,121	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	E, ZIP CODE		
OAKLAWI	N CARE & REHABILITAT	ION CENTED	AWN AVENUE D, MN 56001			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID OIL	PROVIDER'S PLAN OF CORRECTION	N_	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	RIATE	COMPLETE DATE
TAG	ARBOLAIONI ON	ESO INCLUMENT CHARACTERS	ING	DEFICIENCY)		
21390	Continued From page	14	21390			
_,,	Antibiotic monitoring.					
	employee health stat	istics records. Physician		•		
	consultation."	•				
	SUGGESTED METH	OD OF CORRECTION:				
	The director of nursir	ig and/or designee could				
	review/revise policies	and procedures for				
		nd provide education to staff				
	and audit to ensure o					
	TIME DEDIOD FOR	CORRECTION: Twenty-one				
	(21) days.	OCIMEO HOR. INCHIPORC				
	• •					
		•				
		,				
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NAME OF PROVIDER OR SUPPLIER  OAKLAWN CARE & REHABILITATION CENTER  OAKLAWN CARE & REHABILITATION CENTER  SUBMARY STATEMENT OF DEFICIENCIES  REPERTY TAG  REGULATORY OR LISC DIERRIFYMEN INFORMATION)  K 000  INITIAL COMMENTS  FIRE SAFETY  THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEFARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM MILL BE USED AS VERIFICATION OF COMPLIANCE.  UPON RECEIPT OF AN ACCEPTANCE. THAT SUBSTANTIAL COMMENTANCE WITH THE RECULATION FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE RECULATION SHAPE DIVISITOR OF THE FIRST PAGE OF THE CMS-2567 FORM MILL BE USED AS VERIFICATION OF COMPLIANCE.  UPON RECEIPT OF AN ACCEPTANCE.  UPON RECEIPT OF AN ACCEPTANCE THAT SUBSTANTIAL COMPLIANCE WITH THE RECULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.  A LIfe Safety Code Survey was conducted by the Minnesotal Department of Public Safety, Shate Fire Marshall Division, on January 14, 2016. 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/Highligation of National Fire, protection Association (NIFPA) 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:		DF DEFICIENÇIÉS CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING01		SURVEY PLETED	
OAKLAWN CARE & REHABILITATION GENTER  201 OAKLAWN AVENUE MANKATO, NN 66001  PREPRY THE SALE SECULATORY OR LSC IDENTIFYING INFORMATION  REGULATORY OR LSC IDENTIFYING INFORMATION  K 000  INITIAL COMMENTS  FIRE SAFETY  THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-265 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 LIG Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 14, 2016. 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 Code (LSC), Chapter 19 Existing Health Care Occupancies  PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY			245517	e. WNG		01	/14/2016	
REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.  A Lie Safaty Code Survey was conducted by the Minnesota Department of the la mystential compilance with the requirements for participation in Medicare/Medical at 42 CFR, Subpart 483.7(a), Life Safety Code (LiCc), Chapter 19 Existing Health Care Correct Type Type Code (Licc), Chapter 19 Existing Health Care Correct Type Type Type Type Type Type Type Type			10N CENTER	2	101 OAKLAWN AVENUE			
THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WIL 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 January 14, 2016. 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 Code (LSC), Chapter 19 Existing Health Care Occupancies  PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S GROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION	
THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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 Mershal Division, on January 14, 2016. At the time of this survey, Oaktawn 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	K 000		3	K 000	7000000	11	81	
ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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 THAY 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 January 14, 2016. At the time of this survey, Oakfaven 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		FIRE SAFETY					Litt	1
Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or		ALLEGATION OF CODEPARTMENTS AC SIGNATURE AT THE PAGE OF THE CMSUSED AS VERIFICATION RECEIPT OF ONSITE REVISIT OF CONDUCTED TO VASUBSTANTIAL COM REGULATIONS HAS ACCORDANCE WITA LIfe Safety Code S Minnesota Departme Fire Marshal Division the time of this surve Center was found no compliance with the min Medicare/Medica	OMPLIANCE UPON THE CEPTANCE. YOUR EDOTTOM OF THE FIRST 2567 FORM WILL BE TION OF COMPLIANCE.  AN ACCEPTABLE POC, AN EYOUR FACILITY MAY BE ALIDATE THAT IPLIANCE WITH THE EDEEN ATTAINED IN HYOUR VERIFICATION.  URVEY WAS CONDUCTED by the ent of Public Safety, State ent, on January 14, 2016. At y, Oaklawn Health Care to be in substantial requirements for participation if at 42 CFR, Subpart y from Fire, and the 2000 re Protection Association 1, Life Safety Code (LSC), Health Care Occupancies  HE PLAN OF THE FIRE SAFETY AGS) TO:  Decitions invision 1, Suite 145		By Tom Linhoff a	t 1:49 pm	, Feb 12	, 2016

Any deficiency statement ending with an saterisk (\*) denotes a deficiency which the institution may be excused from considing 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.

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

Facility ID; 00088

		ND HUMAN SERVICES  MEDICAID SERVICES			FOR	D: 01/27/2016 MAPPROVED D. 0938-0391
	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245517	B. MNG	170 - 170 - 170 - 170 T	01	1/14/2016
	ROVIDER OR SUPPLIER  N CARE & REHABILITA	TION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 58001	12	
(X4) ID PREFIX YAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH COMRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	Continued From pag	ge 1'	K 000	2		
-	Angela.Kappenman	ney@state.mn.us> and			næ	
		RECTION FOR EACH INCLUDE ALL OF THE RMATION:				
	A description of w to correct the deficie	hat has been, or will be, done noy.			3	
		posed, completion date.				
	<ol> <li>The name and/or responsible for correpresent a reoccurrent</li> </ol>	ction and monitoring to				
	follows:	Center was constructed as was constructed in 1964, is				
-	one-story in height, h fully fire sprinkler pro to be of Type II (000) The 1995 bullding Ad has a partial baseme	as a partial basement, is tected and was determined				
Ø.	The facility has a fire detection in the corridors which is modepartment notification	alarm system with smoke dors and spaces open to the nitored for automatic fire on. The facility has a and had a census of 69 at		tr		

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 81		E BURVEY APLETED
		246517	B. WNG_			0.	1/14/2018
	PROVIDER OR SUPPLIER IN CARE & REHABELITAT	ON CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 01 OAKLAWN AVENUE IANKATO, MN 56001	, ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
K 000 K 050 SS≒D	The requirement at 42 NOT MET as evidence NFPA 101 LIFE SAFE Fire drills are held at a varying conditions, at The steff is familiar with that drills are part of e Responsibility for plant assigned only to compare qualified to exercise less conducted between 9	CFR, Subpart 483.70(a) is ed by: TY CODE STANDARD Inexpected times under least quarterly on each shift. It procedures and is aware stablished routine. Ining and conducting drills is setent persons who are adership. Where drills are	KO		1. Fire drills will be conducted by Of Director at least quarterly on each s with variance of time (at least 90 min variance from previous fire drill on s and varying conditions.  2. Facility will be in compliance by February 23, 2016.	hift, nutes	
	This STANDARD is not Based on documentall interview, the facility fawere conducted once; staff under varying time required by 2000 NFP/Findings include:  On facility tour between on 01/14/16, the review documentation for the particle of the following shifts did times that the drills were a. day - 1st quarter @ 09:27AM	ited to assure fire drills per shift per quarter for all as and conditions as A 101, Section 19.7.1.2.  In 10:00 AM and 12:30 PM of the fire drill past 12 months (January 5) revealed the drills for not sufficiently vary the e conducted:					

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

		& MEDICAID SERVICES			OMB N	O. 0938-03
TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A, BUILDIN	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
IAME OF O	ROVIDER OR SUPPLIER	246517	B, WING_	- 100-1001	01	/14/2016
AKLAW	N CARE & REHABILIT		8	STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 58001		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X6) COMPLETIO DATE
K 050	quarter @ 06:00 Ai	of was confirmed by the	K 05	0		
K 154	Director of Facility II of discovery.  NFPA 101 LIFE SAI Where a required at out of service for more period, the authority and the building is a watch system is prounprotected by the service.	Maintenance (NC) at the time FETY CODE STANDARD  utomatic sprinkler system is pre than 4 hours in a 24-hour having jurisdiction is notified, vacuated or an approved fire vided for all parties left shutdown until the sprinkler turned to service. 9,7.6.1	K 15	1. A separate policy has been do for an automatic sprinkler system out of service for more than 4 ho 24 hour period. 2. Facility will be in compliance b February 11, 2016.	that is	
i i	Where a required au out of service for more period, the authority is and the building is ever vatch system is proven unprotected by the si	not met as evidenced by: utomatic sprinkler system is re than 4 hours in a 24-hour having jurisdiction is notified, vacuated or an approved fire ided for all parties left nutdown until the aprinkler urned to service. 9,7.6.1		*		
p p	n 01/14/2016, obser	en 10:00 AM and 12:30 PM vation and documentation at there was not a single vice plan for the fire				
T	his deficient practice	was confirmed by the				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

MB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 01/14/2018 24RE17 R. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 201 OAKLAWN AVENUE OAKLAWN CARE & REHABILITATION CENTER MANKATO, MN 56001 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 154 Continued From page 4 K 154 Facility Maintenance Director (NC) at the time of discovery. K 155 NFPA 101 LIFE SAFETY CODE STANDARD K 155 SS=D 1. A separate policy has been developed Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, for the fire alarm system when it is out of the authority having jurisdiction is notified, and the service for more than 4 hours a 24 hour building is evacuated or an approved fire watch is period. provided for all parties left unprotected by the shutdown until the fire alarm system has been 2. Facility will be in compliance by returned to service. 9.6.1.8 February 11, 2016. This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 10:00 AM and 12:30 PM on 01/14/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (NC) at the time of discovery.

PRINTED: 01/27/2016

FORM APPROVED



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 2564 January 27, 2016

Ms. Chantel Peterson, Administrator Oaklawn Care & Rehabilitation Center 201 Oaklawn Avenue Mankato, Minnesota 56001

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5517027

Dear Ms. Peterson:

The above facility was surveyed on January 11, 2016 through January 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Oaklawn Care & Rehabilitation Center January 27, 2016 Page 2

Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division #212, St. Cloud MN, 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Original - Facility

Licensing and Certification File

PRINTED: 01/27/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00000		B. WING		04/44/0040		
		00038		D. WIIVO		01/14/2016		
NAME OF PI	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
OAKLAWI	N CARE & REHABILITAT	ON CENTER		AWN AVENUE , 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
2 000	Initial Comments			2 000				
	****ATTENTION*****							
	NH LICENSING CORRECTION ORDER							
	In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.  Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered							
	re-inspection with any result in the assessme	ack of compliance upon titem of multi-part rule ent of a fine even if the eng the initial inspection	will e item					
	that may result from norders provided that a	earing on any assessmon-compliance with the written request is made 15 days of receipt of for non-compliance.	ese de to					
	the following correction When corrections are date, make a copy of original to the Minnes		n and n the alth,					

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00038		B. WING		01/1	4/2016		
	NAME OF PROVIDER OR SUPPLIER  OAKLAWN CARE & REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	CORRECTIVE ACTION SHOULD BE COMP EFERENCED TO THE APPROPRIATE DA			
2 000	Continued From page 1 Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.			2 000					
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care		2 565						
	must be used by all procare of the resident.	ersonnel involved in the							
	by: Based on observation review, the facility failu according to the resid	t is not met as evidence i, interview, and record ed to provide cares ent's written plan of care R69) reviewed for activi	e for						
		d on the admission record osteoarthritis, anxiety e decline.	d						
	(MDS) dated 11/25/15 moderate cognitive im	ige Minimum Data Set 5, indicated R37 had apairment, and required of one staff for dressing	and						
	had oral/dental health multiple missing teeth denture, and a lower pincluded, "Provide set	, and had a full upper							

Minnesota Department of Health

STATE FORM GX6B11 If continuation sheet 2 of 15

PRINTED: 01/27/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
				A. BUILDING: _				
		00038		B. WING		01	/14/2016	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, STAT	E, ZIP CODE			
			201 OAKL	AWN AVENUE				
OAKLAW	N CARE & REHABILITA	TION CENTER		D, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 565	5 Continued From page 2			2 565				
	During observation a 5:53 p.m. R37 was cand had a few natura which were covered R37 stated he hadn't time," and he didn't a because it didn't fit whe drank cold liquids R37's bottom natura to be covered with a particles, and he had mouth.	observed with no up al teeth on the front with a whitish subs t brushed his teeth always wear his top well and would fall of 5. On 1/12/16, at 4: I teeth were again of whitish matter and	oper teeth, t bottom stance. in, "A long o plate out when 10 p.m. observed dark					
	During observation of was sitting on the toil (NA)-F performed per transferred R37 from with a mechanical lift room into the common breakfast. Although assisting R37 with him of offered oral care	let while nursing as ersonal care. NA-F n the toilet to his wh t, and pushed R37 on area of the North NA-F stated she wa is morning cares, R	ssistant neelchair out of the n wing for as finished 137 was					
	When interviewed or stated R37's denture night and then she at the dentures in the night and asked the his teeth in and R37 NA-F pushed R37 by brushed his bottom padhesive, and place searched the cabine stated she did not the dentures. NA-F state assistance in finding the room. While NA-I going to get to scru	es were usually brus ssisted the residen norning. morning. I ut in R37's dentures resident if he wante replied, "Well, why ack into his bathrocoartial, applied dent it in his mouth. Not for R37's top dent ink R37 had any to ed she needed to a R37's top denture, F was gone, R37 a	shed at t to put NA-F s, and ed to put on, ture A-F ture and p ask for and left sked, "Am					

Minnesota Department of Health

STATE FORM 6899 GX6B11 If continuation sheet 3 of 15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPP		` ′	CONSTRUCTION	(X3) DATE COMF	SURVEY
				A. BUILDING: _			
		00038		B. WING		01	/14/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OAKLAWN	CARE & REHABILITAT	ON CENTER	201 OAKLA MANKATO	MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	Continued From page came back into R37's both began looking in denture and it was loo slowly picked up his to applied toothpaste wito brush his bottom nato the bathroom and a brushing. NA-F brush denture adhesive, and R37's mouth. NA-F parea of the North wing table for breakfast. R3 his teeth in and stated since he had them in.  Review of the Oral/De 11/20/15, included R3 full denture, and lowe several missing teeth poor oral hygiene, and to remind/cue him to a [as needed]. Residen teeth with set up."  During interview on 1 registered nurse (RN) refused oral cares and of his mouth, howeve and encouraging oral residents plan of care.  R69's quarterly MDS the resident had seve diagnosis including bru R69's care plan dated required extensive as hygiene including bru R69's care plan dated resident required assi	room with NA-G at R37's room for his cated in R37's room for his cated in R37's room for the some difficulty, a tural teeth. NA-F assisted R37 to finite the top denture diplaced the denture diplaced the denture diplaced the denture diplaced him at a stated it felt good it had been a long difficulty. Also included, R3 difficulty and a brand new repartial denture, at a laso included, R3 difficulty and the summary not do oral cares and at its able to brush him. Also included his determination of the summary not do oral cares and at its able to brush him. Also included his determination of the summary not do oral cares and at its able to brush him. Also included his determination of the summary not do oral cares and at its able to brush him. Also included his determination of the summary not do oral cares and at its able to brush him able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares and at its able to brush his determination of the summary not do oral cares	s top m. R37 e sink, and began returned ish e, applied re in e common at the od to have g time  ated v upper and had ted, "Staff assist pra is own  a. casionally antures out offering ling to the  entified ment had ty, and personal d shaving.  staff	2 565			

Minnesota Department of Health

STATE FORM GX6B11 If continuation sheet 4 of 15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION N			CONSTRUCTION		SURVEY PLETED
				A. BUILDING			
		00038		B. WING		01	/14/2016
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OAKLAWI	N CARE & REHABILITAT	TION CENTER		WN AVENUE MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENC CY MUST BE PRECEDED I LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pagincluding oral cares, assist with washing fiteeth, and to provide morning, bedtime, and During observation of at 7:54 a.m. NA-A as R69 was able to was after being provided assisted the resident perineal care, combinglasses. No oral care R69 during the observation of stated she was compand stated no oral care to the resident, and NR69 was able to perfindependently.  During interview on 1 stated he liked to bruin the morning, howe assisted him with bruin the morning as When interviewed on stated oral cares were day by the nursing as When interviewed on stated oral cares were offered every day, and help as needed.  During interview on 1 stated oral cares were with cares in the morn R69's care plan indicated.	and to set up reside ace and hands and assistance with orand as needed.  If morning cares on sisted R69 to the base his face independent with the washcloth, with dressing, proving his hair, and putties was provided or convation.  If 13/15, at 8:16 a.m. pleted with cares for a was completed on the was completed of the was completed of the was completed of the was not sure to be provided two sesistants.  If 1/14/16, at 9:15 a.m. and should offer assistants.  If 1/14/16, at 11:10 a.m. are expected to be coning and at bedtimes.	brushing al cares  1/13/16, athroom. Idently and NA-A iding ing on offered to  . NA-A . R69, or offered lieved  . R69 ae gets up ae if staff  . RN-A ice per  m. NA-B ad/ or stance or  m. RN-B ompleted e, and	2 565			

Minnesota Department of Health

STATE FORM 6899 GX6B11 If continuation sheet 5 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00038		B. WING		01/1	4/2016
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
OAKLAWI	N CARE & REHABILITAT	ION CENTER	201 OAKLA MANKATO	MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 565	offering and providing according to the residence according to the residence according to the residence according to the facility's Standards of Practice "Dentures in at mornioral care in the mornio	assistance with oral ents plan of care.  s undated policy titled Routine Care including and out at bedtimeing and at bedtime."  OD OF CORRECTIO g and/or designee coollow care plans in retures and services and correct and services and correct and correct and correct and services.	l ed, e. Give N: uld gards audit	2 565			
2 915			2 915				

Minnesota Department of Health

STATE FORM 6899 GX6B11 If continuation sheet 6 of 15

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUR IDENTIFICATION		` ′	CONSTRUCTION	(X3) DATE S COMPL	
				_			
		00038		B. WING		01/1	4/2016
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
OAKLAW	N CARE & REHABILITAT	ION CENTER	201 OAKLA MANKATO	MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETE DATE
2 915	Continued From page	e 6		2 915			
	This MN Requirement by: Based on observation review, the facility fail with grooming for 2 or required staff assistant Findings include: R37's diagnosis noted dated 6/9/11, included disorder, and cognitive R37's significant char (MDS) dated 11/25/19 moderate cognitive in extensive assistance personal hygiene. R37's care plan, upda had oral/dental health multiple missing teeth denture and a lower pincluded, "Provide se oral cares. He is able  During observation at 5:53 p.m. R37 was of and had a few natura which were covered with a which were covered with a which were didn't fit with edrank cold liquids. R37's bottom natural to be covered with a what mouth.	t is not met as end, interview, and of ed to provide ass of 4 residents (R37 ance with personal and on the admission of one attention of one staff for distribution of one staff for distr	document sistance 7, R69) who I hygiene.  In record nxiety  In Set had equired ressing and cated R37 d to apper sons eded for teeth."  In 1/16, at apper teeth, at bottom stance.  In in, "A long p plate out when an observed d dark				

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING: _			
		00038	B. WING		01/	14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
OAKLAM	N CARE & REMARKITAT	201 OAK	LAWN AVENUE			
OAKLAW	N CARE & REHABILITAT	MANKAT	O, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
2 915	Continued From page	e 7	2 915			
	was sitting on the toil (NA)-F performed per transferred R37 from with a mechanical lift room into the commo breakfast. Although Nassisting R37 with his not offered oral cares. When interviewed on stated R37's dentured night and then she as the dentures in the mistated she couldn't rest to put his dentures in and saw his dentures R37 if he wanted to put his denture and stated, "Well, why no into his bathroom, broapplied denture adhermouth. NA-F searched denture and stated sit top dentures. NA-F cassistant care sheet of resident cares) and sand lower [dentures]. R37's top denture, Nask for assistance, and was gone, R37 asked my teeth today?" NA-room with NA-G and R37's room for his toup his toothbrush from toothpaste with some brush his bottom nature.	the toilet to his wheelchair and pushed R37 out of the in area of the North wing for IA-F stated she was finished a morning cares, R37 was during the observation.  1/13/16, at 8:20 a.m. NA-F were usually brushed at esisted the resident to put orning. MA-F member if she helped him, and walked over to R37 were not in. NA-F asked but his teeth in and R37 tt?" NA-F pushed R37 back ushed his bottom partial, sive, and placed it in his ed the cabinet for R37's topine did not think R37 had any checked the nursing (which directs staff on tated, "It says he has upper "When she could not locate A-F stated she needed to ind left the room. While NA-F d, "Am I going to get to scrub the came back into R37's they both began looking in predenture. R37 slowly picked				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O	<sub>=D</sub> .	,	CONSTRUCTION	(X3) DATE COMF	SURVEY
				A. BUILDING			
		00038	E	B. WING	<u></u>	01/	14/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STAT	TE, ZIP CODE		
OAKLAW	N CARE & REHABILITAT	ION CENTER	201 OAKLAW MANKATO, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION	LL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 915	denture adhesive, an R37's mouth. NA-F th common area of the at the table for break to have his teeth in a time since he had the Review of dental hyg Minneapolis Veteran' 5/11/15, indicated R3 calculus and heavier throughout the remai "Personal Oral Hygie stay on each area for Needs to use daily properties of the Oral/D 11/20/15, included R3 full denture, and lowe several missing teeth poor oral hygiene, and to remind/cue him to [as needed]. Resident teeth with set up."  During an interview or registered nurse (RN refused oral cares and his mouth, however and encouraging ora. R69's quarterly MDS the resident had seved diagnosis including drequired extensive as hygiene including brunch for the resident required asserties.	d placed the denture in nen pushed R37 into the North wing, and placed fast. R37 stated it felt gond stated it had been a em in.  iene progress notes from a Administration dated in had moderate amoun amounts of plaque found ning teeth. Also included ne: poor. Patient needs in a longer amount of time foxy brush!"  ental Evaluation dated in had a brand new upper partial denture, and had had the summary noted, "do oral cares and assist it is able to brush his own and 1/13/16, at 2:26 p.m.  p)-D stated R37 occasion doften took his denture er, staff should be offerir	him bod long m the ts of id d, to e. er ad d Staff t prn /n mally is out ing ed thad id sonal ving. that	2 915			

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STATE FORM 6899 GX6B11 If continuation sheet 9 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>I</b> ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00038	B. WING		01	/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
OAKLAW	N CARE & REHABILITAT	ION CENTER	KLAWN AVENUE ATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
2 915	teeth, and to provide morning, bedtime, and During observation or was in his room, unship cheeks approximately length, and chin hair a On 1/12/16, at 3:39 p dayroom, watching te unshaven.  During observation of at 7:54 a.m. NA-A ass R69 was able to wash after being provided vassisted the resident perineal care, combin glasses. No oral care offered to R69 during Additional observation 11:08 a.m., and 1/14/resident remained unstated she was compand stated no oral care or offered to the residable to perform oral care or offe	ace and hands and brushing assistance with oral cares d as needed.  In 1/12/16, at 9:56 a.m. R69 haven, with hair along his y four millimeters (mm) in approximately two mm.  Im. R69 was observed in the elevision and remained  If morning cares on 1/13/16, sisted R69 to the bathroom. In his face independently with the washcloth, and NA-A with dressing, providing and his hair, and putting on the observation.  In so of R69 on 1/13/16, at 16, at 9:10 a.m., the shaven.  In 13/15, at 8:16 a.m. NA-A leted with cares for R69, re or shaving was completed lent. NA-A stated R69 was	2 915			
		e to be provided twice per				

Minnesota Department of Health

STATE FORM GX6B11 If continuation sheet 10 of 15

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00038		B. WING		01/1	4/2016	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
OAKLAWI	N CARE & REHABILITATI	ON CENTER	201 OAKLA MANKATO,	WN AVENUE MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 915	Continued From page	: 10		2 915				
	day by the nursing assistants.							
	When interviewed on stated oral cares were offered every day, and help as needed. Shar every day on males.	e to be provided a d should offer ass	nd/ or istance or					
	During interview on 1/14/16, at 11:10 a.m. RN-B stated oral cares were expected to be completed with cares in the morning and at bedtime, and shaving was to be offered daily. RN-B stated R69's care plan indicated assist of one staff for grooming and oral cares, and staff should be offering and providing assistance with all personal cares.							
	Review of the facility's Standards of Practice "Dentures in at morning oral care in the morning	Routine Care inc ng and out at bed	luded, time. Give					
	SUGGESTED METHO director of nursing and or revise policies, and regarding resident gro Assessment and Assu could do random audi	d/or designee cou I provide educatio ooming. The Qua urance (QAA) con	ld review n for staff lity nmittee					
	TIME PERIOD FOR (21) days.	CORRECTION: TV	venty-one					
21390	MN Rule 4658.0800 S	Subp. 4 A-I Infection	on Control	21390				
	Subp. 4. Policies and control program must procedures which pro	include policies a vide for the follow	nd ving:					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE S	
				A. BUILDING: _			
		00038		B. WING	<del> </del>	01/1	14/2016
NAME OF P	ROVIDER OR SUPPLIER	STR	EET ADDR	ESS, CITY, STA	TE, ZIP CODE		
OAKLAWI	N CARE & REHABILITAT	ION CENTER		WN AVENUE MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	collection to identify nosocomial infections in residents;  B. a system for detection, investigation, and control of outbreaks of infectious diseases;  C. isolation and precautions systems to reduce risk of transmission of infectious agents;  D. in-service education in infection prevention and control;  E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;  F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as			21390			
	practices, including a tuberculosis program as defined in part 4658.0815;  G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.  This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement an infection control program that included ongoing surveillance of resident infections which included tracking and trending resident name and location in the facility, signs and symptoms of infections, date of onset, identified microorganism, treatment, and/or date of resolution of infection. This had the potential to affect all 69 residents currently residing in the facility.  Findings include:						

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMF	PLETED
		00038	B. WING		01	/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
			LAWN AVENUE	,		
OAKLAW	N CARE & REHABILITAT	ION CENTER	O, MN 56001			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC	TION SHOULD BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
					,	
21390	Continued From page	e 12	21390			
	The facility's infection	control logs were reviewed				
	from July 2015, throu	gh December 2015. The				
	facility utilized a form	titled Continuous Quality				
	Improvement, Monthl					
		lentified types of infection				
	_	(UTI), upper respiratory,				
		strointestinal, skin, eye, ear,				
		temic, unexplained febrile bus) site, vaginal, and other				
		d tally marks were made				
	The state of the s	ection, and identified as,				
		al acquired]" or "Socomial				
	1	Other columns identified				
		er," "Total," "Resolved," and				
	"Rate." The infections	were tallied according to				
	category.					
	A review of the Contin	nuous Quality Improvement,				
		ection Statistics form for				
	September 2015, indi					
		ided four urinary tract				
	· ·	nfections, one urinary tract				
	catheter related infect	tion, five lower respiratory				
	infections, one gastro	intestinal tract infection, five				
	1	vo other sites of infection.				
		der the, "Nosocomial"				
	_	mprovement Conclusion				
		blank. The documentation ication of the resident,				
		location of the resident,				
	and symptoms, date					
	1	ment, or date of resolution.				
		ce of ongoing surveillance,				
	tracking, or summariz					
		entify if there was a pattern.				
	A rovious of the Contin	augus Quality Improvement				
		nuous Quality Improvement,				
	Monthly Resident Infection Statistics form for November 2015, indicated there were 8 UTI's					

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00038	B. WING		01/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
OAKLAW	N CARE & REHABILITAT	ION CENTER 201 OAK	LAWN AVENUE		
OARLAW	TOAKE & KENABIENAN	MANKAT	O, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21390	identified as "Nosocol corresponding Order the monthly antibiotic pharmacist, identified South East Wing, 3 reantibiotics for UTI, on were treated with anti South West Wing, on UTI. Although the Collimprovement, Monthly Statistics form for November they were local microorganism was, a effective.  During interview on 1 registered nurse (RN) of the facility infection nurse managers met discussed resident information was not treat information was not treat infection program, and documentation which summary of infections.  The facility policy date Control Surveillance is control nurse does su and Socomial infection reports and other performance in communication communic	mial" infections. The Listing Report, which was use report run by the in November 2015, on the esidents were treated with the North Wing, 2 residents biotics for UTI, and on the er resident was treated for intinuous Quality y Resident Infection vember 2015, indicated UTI's, there was no entation which indicated being tracked for UTI's, ted in the facility, what the and if the antibiotic was  13/16, at 1:30 p.m. 1-E, who was also in charge control program, stated the every morning and fections. RN-E stated the ally antibiotic use reports sidents name, name of e started. However, this facked with the actual d there was no included any monthly and/ or trends identified.  12/24/15, titled Infection indicated the infection recillance of Nosocomial ins by: "Review of culture inent lab data. Nurse iral. Chart review. Review	21390		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00038	B. WING		01	/14/2016
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STAT	E, ZIP CODE		
OAKLAW	N CARE & REHABILITAT	ION CENTER	AKLAWN AVENUE (ATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21390	Antibiotic monitoring. employee health staticonsultation."  SUGGESTED METH The director of nursin review/revise policies infection control survey collection/analysis, and audit to ensure collection control.	Maintenance of the stics records. Physician  OD OF CORRECTION: g and/or designee could and procedures for eillance and data and provide education to staff	21390			

Minnesota Department of Health

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