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

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.

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,

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GX6B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00038

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **953692000**

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

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **04/15/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

Mandatory DPNA effective 4/15/2016, is rescinded effective 4/14/2016.

17. SURVEYOR SIGNATURE Date :
Larry Gannon, DSFM 04/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS
Posted 05/09/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/02/2016
(L33)

DETERMINATION APPROVAL

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

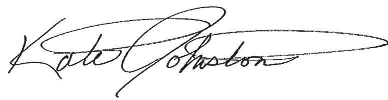
Your facility's Medicare approved area consists of all 77 skilled nursing facility beds.

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.

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

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

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))

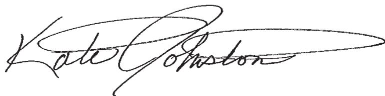
The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 14, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 14, 2016, is to be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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245517	A. Building B. Wing	2/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN CARE & REHABILITATION 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).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 02/23/2016	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 02/23/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 02/23/2016
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 02/23/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) JS/KJ	DATE 05/05/2016	SIGNATURE OF SURVEYOR 29249	DATE 02/29/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245517	A. Building 01 - MAIN BUILDING 01 B. Wing	4/15/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN CARE & REHABILITATION 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 02/23/2016	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 02/11/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 02/11/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/05/2015	SIGNATURE OF SURVEYOR 35482	DATE 04/15/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245517 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	4/15/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN CARE & REHABILITATION 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0022	Correction Completed 03/11/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 04/14/2016	ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 04/01/2016
ID Prefix Reg. # NFPA 101 LSC K0034	Correction Completed 04/01/2016	ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 03/07/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 04/14/2016
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/01/2016	ID Prefix Reg. # NFPA 101 LSC K0146	Correction Completed 04/14/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 04/01/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/05/2016	SIGNATURE OF SURVEYOR 35482	DATE 04/15/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GX6B
Facility ID: 00038

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **953692000**

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

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

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

8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **01/14/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited — 1 TJC
2 AOA — 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:

____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel	___ 6. Scope of Services Limit
___ 3. 24 Hour RN	___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF)	___ 8. Patient Room Size
___ 5. Life Safety Code	___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HPR Social Work Specialist 02/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

Posted 03/14/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/02/2016
(L33)

DETERMINATION APPROVAL

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:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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

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

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

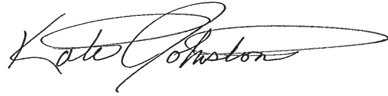
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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 all 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 https://dab.efile.hhs.gov/. 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 https://dab.efile.hhs.gov/user_sessions/new 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 **all** 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 no later than 60 days 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING ______ B. WING ______	01/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5517017 was completed and found not to be substantiated.	F 000	accepted 2/17/16	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and 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 daily living (ADLs). Findings include: R37's diagnosis noted on the admission record dated 6/9/11, included osteoarthritis, anxiety disorder, and cognitive decline.	F 282	1. R37 care plan has been updated for oral cares to be assist of one. 2. R69 oral care will be provided per care plan. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The OHL, DON or designee will conduct weekly audits for NARs following oral and grooming care per care plans. Audits will continue 4x per month x 3 months and gradually decrease audits until data allows.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2/15/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING ______ B. WING ______	01/14/2016

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F 282	Continued From page 1 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." 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, "A long 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	F 282	4. Care plans reviewed by nurse managers of each unit to ensure oral and grooming care are addressed appropriately for each individual resident. 5. NARs have an individual skills review/ competency on oral and grooming care by Corporate Education Director, DON, OHL or designee. 6. NARs and nurses will review the oral and grooming cares/care plan expectations 7. Compliance of oral care per care plan wil be reviewed in quarterly QA/CQI meeting. 8. Facility will be in compliance by February 23, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 2	F 282		

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 came back into R37's room with NA-G and they both began looking in R37's room for his top denture and it was located in R37's room. R37 slowly picked up his toothbrush from the sink, applied toothpaste with some difficulty, and began to brush his bottom natural teeth. NA-F returned to the bathroom and assisted R37 to finish brushing. NA-F brushed the top denture, applied denture adhesive, and placed the denture in R37's mouth. NA-F pushed R37 into the common area of the North wing, and placed him at the table for breakfast. R37 stated it felt good to have his teeth in and stated it had been a long time since he had them in.

Review of the Oral/Dental Evaluation dated 11/20/15, included R37 had a brand new upper full denture, and lower partial denture, and had several missing teeth. Also included, R37 had poor oral hygiene, and the summary noted, "Staff to remind/cue him to do oral cares and assist prn [as needed]. Resident is able to brush his own teeth with set up."

During interview on 1/13/16, at 2:26 p.m. registered nurse (RN)-D stated R37 occasionally

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 refused oral cares and often took his dentures out of his mouth, however, staff should be offering and encouraging oral cares daily according to the residents plan of care. R69's quarterly MDS dated 10/28/15, identified the resident had severe cognitive impairment had diagnosis including dementia and anxiety, and required extensive assist of one staff for personal hygiene including brushing his teeth and shaving. R69's care plan dated 11/6/15, directed staff resident required assist of one with grooming including oral cares, and to set up resident to assist with washing face and hands and brushing teeth, and to provide assistance with oral cares morning, bedtime, and as needed. 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 was provided or offered to R69 during the observation. 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 was completed or offered to the resident, and NA-A stated she believed R69 was able to perform oral cares 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 brushing his teeth.	F 282		

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	245517	A. BUILDING ____ B. WING ____	01/14/2016

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F 282	Continued From page 4 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 offered every day, and should offer assistance or help as needed. 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 R69's care plan indicated assist of one staff for grooming and oral cares, and staff should be 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."	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with grooming for 2 of 4 residents (R37, R69) who required staff assistance with personal hygiene. Findings include:	F 311	1. R37 care plan has been updated for oral cares to be assist of one. Oral care will be provided per care plan. 2. R69 oral care will be provided per care plan. Care plan and NAR care sheets have been updated to assist of one with shaving. 3. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The Corporate Education Director, OHL, DON or designee will conduct weekly audits to ensure oral cares and grooming is being completed properly. Audits will continue 4x per month x 3 months and gradually decrease audits until data allows.	

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F 311	Continued From page 5 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, updated 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." 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, "A long 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	F 311	Audits will be completed for a random sample of residents each week to ensure oral care and grooming is being completed and offered to residents individual care plan. 4. NARs will be inserviced by Corporate Education Director, DON, OHL or designee on offering and providing proper oral cares and grooming per resident care plan. 5. NARs and nurses will review and sign to agree that they understand proper ADL cares for all residents. 6. Review compliance of grooming and oral cares in the quarterly QA/CQI meeting. 7. Facility will be in compliance by February 23, 2016.	

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F 311	Continued From page 6 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 couldn't remember if she helped him to put his dentures in, and walked over to R37 and saw his dentures were not in. NA-F asked R37 if he wanted to put his teeth in and R37 stated, "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 checked the nursing assistant care sheet (which directs staff on resident cares) and stated, "It says he has upper and lower [dentures]." When she could not locate R37's top denture, NA-F stated she needed to ask for assistance, and left the room. While NA-F was gone, R37 asked, "Am I going to get to scrub my teeth today?" NA-F came back into R37's room with NA-G and they both began looking in R37's room for his top denture. R37 slowly picked up his toothbrush from the sink, applied toothpaste with some difficulty, and began to brush his bottom natural teeth. NA-F located R37's top denture in the residents room, returned to the bathroom, and assisted R37 to finish brushing. NA-F brushed the top denture, applied denture adhesive, and placed the denture in R37's mouth. NA-F then pushed R37 into the common area of the North wing, and placed him at the table for breakfast. R37 stated it felt good to have his teeth in and stated it had been a long time since he had them in. Review of dental hygiene progress notes from the	F 311		

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F 311	Continued From page 7 Minneapolis Veteran's Administration dated 5/11/15, indicated R37 had moderate amounts of calculus and heavier amounts of plaque found throughout the remaining teeth. Also included, "Personal Oral Hygiene: poor. Patient needs to stay on each area for a longer amount of time. Needs to use daily proxy brush!" Review of the Oral/Dental Evaluation dated 11/20/15, included R37 had a brand new upper full denture, and lower partial denture, and had several missing teeth. Also included, R37 had poor oral hygiene, and the summary noted, "Staff to remind/cue him to do oral cares and assist prn [as needed]. Resident is able to brush his own teeth with set up." During an interview on 1/13/16, at 2:26 p.m. registered nurse (RN)-D stated R37 occasionally refused oral cares and often took his dentures out of his mouth, however, staff should be offering and encouraging oral cares daily. R69's quarterly MDS dated 10/28/15, identified the resident had severe cognitive impairment had diagnosis including dementia and anxiety, and required extensive assist of one staff for personal hygiene including brushing his teeth and shaving. R69's care plan dated 11/6/15, directed staff that resident required assist of one with grooming including oral cares, and to set up resident to 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	F 311		

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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 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 offered every day, and should offer assistance or	F 311		

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

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F 311	Continued From page 9 help as needed. Shaving was to be completed every day on males. 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 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."	F 311	1. R128 has discharged from facility. 2. R66 plan of care will be updated for ambulation; resident will ambulate with one assist with wheelchair behind resident. 3. Education will be provided to staff on proper transportation with 4 wheel walker. Also, education to staff to notify maintenance director or housekeeping director if noted a concern with resident equipment, including 4WW. 4. Staff will review and sign off on proper/competency of use of 4 wheel walker. 5. Designee will complete a weekly audit to ensure all 4 wheeled walkers meet safety standards per manufacturer's recommendations. Audits will continue 4x per month x 3 months and gradually decrease until data allows. 6. All current residents will be re-evaluated by therapy to ensure residents understand proper use of 4WW. All residents will be assessed at admission for proper use of 4WW. 7. Review compliance of 4WW in quarterly QA/CQI meeting. 8. Facility will be compliance by February 23rd, 2016.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R128 and R66) were appropriately assessed for safe use of a four-wheeled walker (4WW), with the walkers being utilized in a manner consistent with the manufacturer's recommendations, and remaining in safe working order with properly functioning brakes.	F 323		

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Findings include:

R128's Diagnosis Report dated 1/13/16, identified diagnoses including dementia and hearing loss with cochlear implant status.

R128's admission Minimum Data Set (MDS) dated 12/29/15, identified R128's cognition was severely impaired and required limited assistance for most activities of daily living (ADLs).

R128's Care Area Assessment (CAA) dated 1/4/16, identified R128 required limited assistance from one staff with the use of a gait belt and walker, for transfers and ambulation. The CAA noted R128 often self-transferred secondary to her cognitive deficits, and directed staff to provide ongoing reminders for R128 to obtain assistance with transfers, while following her physical therapist's (PT) instructions for mobility. The CAA also identified R128 had received occupational therapy (OT) services.

The PT Daily Treatment Note from 1/6/16, noted R128 had good balance, but needed verbal cues with directions on where to go, even in a familiar environment. The note indicated R128 was instructed on the use of a 4WW and nursing was directed to begin using the 4WW, with assistance from one staff for cues with directions. The corresponding PT and OT communication Note dated 1/6/16, directed nursing to use a 4WW for R128, with assistance from one staff for all transfers and to/from the bathroom.

R128's care plan dated 1/12/16, directed staff to evaluate and discuss the potential need for memory care with R128 and her family,

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F 323	Continued From page 11 addressing limitations, risks, and needs in relation to her cognitive impairment and safety. The care plan indicated, "[R128] has confusion and forgetfulness, altered mobility (needs someone to walk with her at all times), has a severe hearing impairment and cochlear implant..." The care plan instructed, "Ensure that adaptive equipment that [R128] needs is provided and is present and functional (glasses, hearing aid, walker)... Transfer and ambulate with limited assist of 1 [one], gait belt and walker or per PT instructions." Additional care planned interventions included providing R128 with reminders not to self-transfer, assisting her with reorientation and redirection, ensuring her hearing device was in place, reproaching her as needed, and monitoring and documenting on her safety. During observation of the evening meal on 1/11/16, at 5:20 p.m. R128 ambulated independently with the use of a 4WW, approximately 50 feet across the dining room. No nursing staff were present in the dining room at the time. Once across the dining room, R128 stopped ambulating, pulled the 4WW behind her and sat on the seat of the walker without first applying the brakes. R128's 4WW was observed to roll backward about six inches as she sat down. After her buttock reached the seat, the walker continued to roll back approximately one foot, with her feet extended out in front of her. She then stood up from the seat, again failing to apply the breaks to the 4WW. As she pushed up on the handles to aid in standing up, the walker rolled back slightly and she quickly sat back down. R128 made two additional attempts to stand with the walker rolling before successfully reaching a standing position. At this time, an unidentified nursing assistant (NA) entered the	F 323		

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F 323	Continued From page 12 dining room, approached R128 and offered to walk with her back to her room. R128 turned around to face the walker, requiring the walker to steady herself as she turned, and R128 then left the dining room using her 4WW receiving assistance by the NA. During observation on 1/13/16, at 7:47 a.m. registered nurse (RN)-B assisted R128 with toileting. RN-B applied a gait belt to R128 while she was in a seated position on her bed in her room. RN-B placed the 4WW in front of R128 and set the bilateral brakes, and R128 stood from the bed with stand-by assistance. R128 began to walk with the 4WW without unlocking the brakes. RN-B stated, "Brakes off," but R128 continued walking with the brakes locked on the walker. R128's hearing device was not in place at the time of this observation. RN-B unlocked the right brake as R128 continued in a forward motion and prompted, "Hold on to your walker," as she held the 4WW in front of R128, while walking with her to the bathroom. Though the left brake remained in place, the wheel continued to roll with ease. Throughout toileting and returning to her bed, R128 continued to require RN-B to apply or disengage the brakes of her 4WW. R128 did not apply or release the brakes to her 4WW at any point during this observation. During interview on 1/13/16, at approximately 7:55 a.m. NA-E confirmed she was one of R128's primary staff, and stated R128 did well with applying/ releasing the 4WW brakes, when prompted by staff, and if she had her hearing device in. On 1/13/16, at 8:35 a.m. PT-A (director of the facility's PT program) and PT-B were interviewed	F 323		

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regarding R128's use of the 4WW. PT-A stated cognition and physical ability were some of the factors used in determining which type of walker was most appropriate for a resident, and stated for a 4WW they assessed whether a resident could comprehend how to apply the brakes of the walker, and whether the resident had the judgement/ awareness to know when it was appropriate to do so. Once informed of the above observations of R128's use of the 4WW, PT-A stated R128 may require a re-evaluation to address her safety with the use of a 4WW. PT-B stated R128 had been assessed to be provided assistance from one staff when using the 4WW. PT-B stated she routinely worked with R128, and due to her cognition and impulsivity, R128 needed an assist of one staff and should always have staff present to provide prompting and ensure appropriate use of the 4WW. PT-B stated if R128's amplifier (hearing device) was applied appropriately, she did well with following staff prompts and used the 4WW appropriately.

During observation on 1/13/16, at 8:53 a.m. PT-B went into R128's room to complete the residents therapy session. R128 had not yet dressed for the day, so PT-B began to provide assistance to R128 to complete her morning cares. As R128 sat at the side of her bed, PT-B applied her amplifier/ hearing device, applied a gait belt, and then placed the 4WW in front of her. Throughout the entire observation of cares, R128 did not apply or disengage the brakes of the 4WW until prompted to do so. PT-B provided this prompting through use of the bathroom, dressing, grooming, ambulating to the dining room, and sitting in her chair at the dining room table. PT-B stated it was typical for R128 to require this level of prompting to use the 4WW appropriately. During this

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observation, the left front wheel of the 4WW was again noted to continue rolling, despite the brake being engaged.

During observation on 1/13/16, at 9:26 a.m. NA-C and NA-D provided stand-by assist with the use of a gait belt and 4WW while R128 ambulated back to her room. R128 again required constant prompts for locking and unlocking the brakes to the 4WW, but was compliant with following those prompts.

On 1/13/16, at 9:35 a.m. PT-B was observed ambulating with R128 to the therapy room. PT-B confirmed the left brake of R128's 4WW was not working, and while the left brake was engaged, the walker rolled forward and backward. PT-B immediately stated she would inform maintenance and have them repair the brake right away.

On 1/14/16, at 9:22 a.m. R128 was observed seated in the facility's day room, with a different walker placed next to her, and the 4WW was observed in the PT room.

During interview on 1/14/16, at 9:35 a.m. NA-E stated PT made a change to R128's walker, and PT was concerned with her unsafe use of the walker and, "She [R128] had developed a habit of like sitting on it and pushing herself backwards... [and] walking, when pulling it [the 4WW] behind her." NA-E stated she had observed R128 doing this in the past, and she had attempted to intervene and re-educate R128 on the safe use of her 4WW each time she observed this. NA-E was not aware R128's left brake to the 4WW was not engaging properly.

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F 323	Continued From page 15 During interview on 1/14/16, at 10:17 a.m. RN-B stated she had seen R128 make multiple self-transfer attempts and had received reports of self-transfer and self-ambulating attempts. However, RN-B stated she did not know R128 was using her 4WW in an unsafe manner and the left-front brake was not working. At 1:56 p.m. RN-B stated there was no set schedule to evaluate maintenance needs for walkers, however, if staff noticed repairs needed on any resident equipment, they should be notifying maintence immediately. R66's Order Summary Report dated 1/11/16, identified diagnoses including pulmonary heart disease, atrial fibrillation, hypertension, and osteoporosis. R66's quarterly MDS dated 12/21/15, identified R66 had moderately impaired cognition and was independent with most ADLs. R66's undated ADL CAA noted R66 was unstable with transfers and ambulation, but was able to stabilize herself without staff assistance.. The CAA identified R66 was independent with the use of a wheeled walker for transfers and ambulation. R66's care plan dated 1/12/16, noted R66 was independent with ADLs, transfers, and ambulation, but directed staff to provide her with assistance as needed/ requested. The care plan identified R66 demonstrated shortness of breath on exertion and was currently oxygen dependent, and staff was directed to monitor for cyanosis, shortness of breath, and increased respirations, while encouraging periods of rest and administering oxygen as needed.	F 323		

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	245517	A. BUILDING ______ B. WING ______	01/14/2016

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F 323	Continued From page 16	F 323		

During observation on 1/11/16, at 5:49 p.m. RN-A was observed propelling R66 from the dining room area, down the main hallway 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 R66's oxygen saturation and stated the saturation was low and she needed to administer her oxygen. RN-C proceeded to propel the walker down the Southeast hallway to her resident room, while R66 remained seated on the bench of the 4WW.

During interview on 1/11/16, at 6:33 p.m. R66 stated facility staff routinely pushed her while she sat on the bench of her 4WW.

During interview on 1/13/16, at 8:35 a.m. PT-A stated it was not a safe practice to propel a 4WW while a resident 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 9:51 a.m. RN-A stated she had never transported R66 by propelling her on the 4WW in the past, however, she felt there was some urgency to transport R66 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 (R66's care manager) stated R66 had her own wheelchair which was used for some outings or longer distances, and the wheelchair was kept in

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F 323	Continued From page 17 R66's room. Review of a Correction, Direction, or Re-education Form signed 1/14/16, indicated during the day shift on 1/12/16, R66 was walking to the dining room with her 4WW when she became tired. The activity director (AD) approached R66 and encouraged her to sit on her walker bench for a period to rest. R66 was noted to state, "Push me up to the table... Just push me up to the table we are almost there." AD proceeded with propelling R66 while she remained seated on the bench of her 4WW. During interview on 1/14/16, at 2:11 p.m. AD confirmed she was aware it was not appropriate to transport residents while they were seated on a 4WW and referred to this situation as, "A total lapse of judgement." Assembly, Installation and Operating Instructions for the Rollater 4WW (manufacturer's instructions) dated 6/10, directed, "Each individual should ALWAYS consult with their physician or therapist to determine proper adjustment and usage. DO NOT use the rollator as a wheelchair or transport device. Rollators are not intended to be propelled while seated. The brakes MUST be in the locked position before using the seat. A physical/occupational therapist should assist in the height adjustment of the rollator for maximum support and correct brake activation... When using the rollator in a stationary position, the hand brakes MUST be locked..." The instructions also directed routine care and maintenance, including, "Verify operation of the brakes and have them adjusted if necessary... Inspect wheels periodically for wear or damage... Replace any broken, damaged or worn items immediately..."	F 323		

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F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	1. All residents currently residing in the facility have been reviewed for infections. 2. Ongoing, all residents' infections are reviewed and discussed daily (Monday-Friday) by Interdisciplinary Team. 3. Facility has developed Continuous Quality Improvement resident infection statistic form. The infection statistic form monitors residents, room location, diagnosis, microorganism, antibiotic, facility or community acquired and symptoms.. OHL Director will complete the form to track and analysis infections. This form will assist in the reduction of transmission to other residents in the facility. 4. Infections will be tracked, trended continuously, and an analysis will be completed on a monthly basis. Monthly data collected and reviewed in the quarterly QA/CQI meeting. 5. Facility will be in compliance by February 23, 2016.	

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F 441	Continued From page 19	F 441		

This 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:

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

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F 441	Continued From page 20 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 identified as "Nosocomial" infections. The corresponding Order Listing Report, which was the monthly antibiotic use report run by the pharmacist, identified in November 2015, on the South East Wing, 3 residents were treated with antibiotics for UTI, on the North Wing, 2 residents were treated with antibiotics for UTI, and on the South West Wing, one resident was treated for UTI. Although the Continuous Quality Improvement, Monthly Resident Infection Statistics form for November 2015, indicated there were 8 resident UTI's, there was no corresponding documentation which indicated which residents were being tracked for UTI's, where they were located in the facility, what the microorganism was, and if the antibiotic was effective. During interview on 1/13/16, at 1:30 p.m. registered nurse (RN)-E, who was also in charge of the facility infection control program, stated the nurse managers met every morning and discussed resident infections. RN-E stated the pharmacist ran monthly antibiotic use reports	F 441		

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

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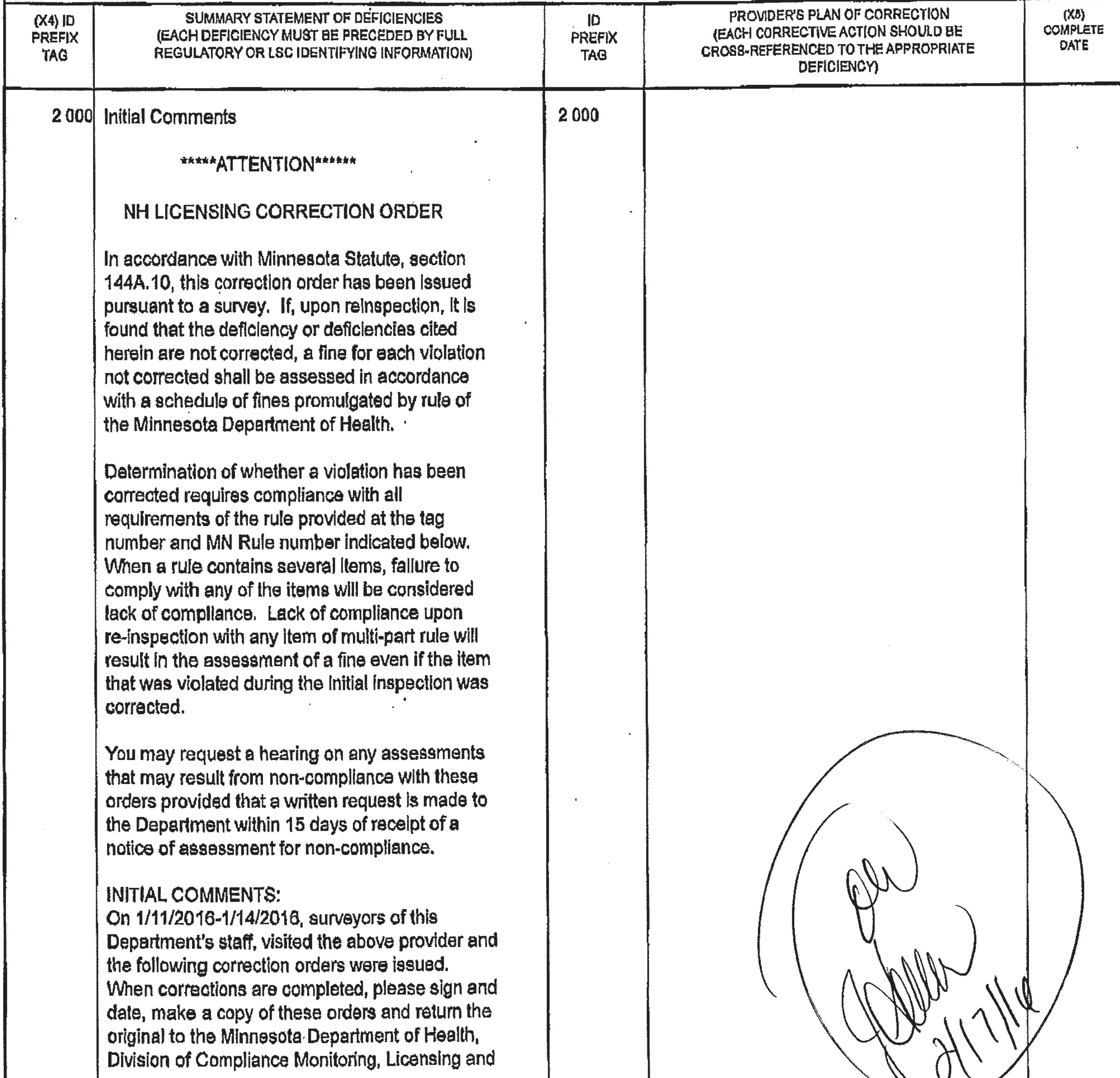
F 441	Continued From page 21 which included the residents name, name of antibiotic, and the date started. However, this information was not tracked with the actual infection program, and there was no documentation which included any monthly summary of infections and/ or trends identified. The facility 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. Physician consultation."	F 441		

Minnesota Department of Health



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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/11/2016-1/14/2016, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	2/17/16	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 2/15/16

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.

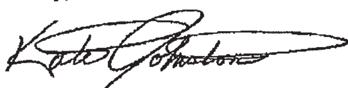
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division #212, St. Cloud MN, 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your 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
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P.O. Box 64900
St. Paul, Minnesota 55164-0900
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Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Original - Facility
Licensing and Certification File

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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 must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: 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 daily 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."	2 565		

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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, "A long 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	2 565		

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2 565	Continued From page 3 came back into R37's room with NA-G and they both began looking in R37's room for his top denture and it was located in R37's room. R37 slowly picked up his toothbrush from the sink, applied toothpaste with some difficulty, and began to brush his bottom natural teeth. NA-F returned to the bathroom and assisted R37 to finish brushing. NA-F brushed the top denture, applied denture adhesive, and placed the denture in R37's mouth. NA-F pushed R37 into the common area of the North wing, and placed him at the table for breakfast. R37 stated it felt good to have his teeth in and stated it had been a long time since he had them in. Review of the Oral/Dental Evaluation dated 11/20/15, included R37 had a brand new upper full denture, and lower partial denture, and had several missing teeth. Also included, R37 had poor oral hygiene, and the summary noted, "Staff to remind/cue him to do oral cares and assist prn [as needed]. Resident is able to brush his own teeth with set up." During interview on 1/13/16, at 2:26 p.m. registered nurse (RN)-D stated R37 occasionally refused oral cares and often took his dentures out of his mouth, however, staff should be offering and encouraging oral cares daily according to the residents plan of care. R69's quarterly MDS dated 10/28/15, identified the resident had severe cognitive impairment had diagnosis including dementia and anxiety, and required extensive assist of one staff for personal hygiene including brushing his teeth and shaving. R69's care plan dated 11/6/15, directed staff resident required assist of one with grooming	2 565		

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2 565	Continued From page 4 including oral cares, and to set up resident to assist with washing face and hands and brushing teeth, and to provide assistance with oral cares morning, bedtime, and as needed. 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 was provided or offered to R69 during the observation. 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 was completed or offered to the resident, and NA-A stated she believed R69 was able to perform oral cares 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 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 offered every day, and should offer assistance or help as needed. 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 R69's care plan indicated assist of one staff for grooming and oral cares, and staff should be	2 565		

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2 565	Continued From page 5 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.	2 565		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING: ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 915	Continued From page 6	2 915		

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide assistance with grooming for 2 of 4 residents (R37, R69) who required staff assistance with personal hygiene.

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, updated 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."

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, "A long 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.

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2 915	Continued From page 7 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 couldn't remember if she helped him to put his dentures in, and walked over to R37 and saw his dentures were not in. NA-F asked R37 if he wanted to put his teeth in and R37 stated, "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 checked the nursing assistant care sheet (which directs staff on resident cares) and stated, "It says he has upper and lower [dentures]." When she could not locate R37's top denture, NA-F stated she needed to ask for assistance, and left the room. While NA-F was gone, R37 asked, "Am I going to get to scrub my teeth today?" NA-F came back into R37's room with NA-G and they both began looking in R37's room for his top denture. R37 slowly picked up his toothbrush from the sink, applied toothpaste with some difficulty, and began to brush his bottom natural teeth. NA-F located R37's top denture in the residents room, returned to the bathroom, and assisted R37 to finish brushing. NA-F brushed the top denture, applied	2 915		

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	00038	A. BUILDING: ____ B. WING ____	01/14/2016

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2 915	Continued From page 8	2 915		

denture adhesive, and placed the denture in R37's mouth. NA-F then pushed R37 into the common area of the North wing, and placed him at the table for breakfast. R37 stated it felt good to have his teeth in and stated it had been a long time since he had them in.

Review of dental hygiene progress notes from the Minneapolis Veteran's Administration dated 5/11/15, indicated R37 had moderate amounts of calculus and heavier amounts of plaque found throughout the remaining teeth. Also included, "Personal Oral Hygiene: poor. Patient needs to stay on each area for a longer amount of time. Needs to use daily proxy brush!"

Review of the Oral/Dental Evaluation dated 11/20/15, included R37 had a brand new upper full denture, and lower partial denture, and had several missing teeth. Also included, R37 had poor oral hygiene, and the summary noted, "Staff to remind/cue him to do oral cares and assist prn [as needed]. Resident is able to brush his own teeth with set up."

During an interview on 1/13/16, at 2:26 p.m. registered nurse (RN)-D stated R37 occasionally refused oral cares and often took his dentures out of his mouth, however, staff should be offering and encouraging oral cares daily.

R69's quarterly MDS dated 10/28/15, identified the resident had severe cognitive impairment had diagnosis including dementia and anxiety, and required extensive assist of one staff for personal hygiene including brushing his teeth and shaving.

R69's care plan dated 11/6/15, directed staff that resident required assist of one with grooming including oral cares, and to set up resident to

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2 915	Continued From page 9 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	2 915		

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2 915	Continued From page 10 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 offered every day, and should offer assistance or help as needed. Shaving was to be completed every day on males. 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 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 review or revise policies, and provide education for staff regarding resident grooming. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data	21390		

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21390	Continued From page 11	21390		

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 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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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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21390	Continued From page 13 identified as "Nosocomial" infections. The corresponding Order Listing Report, which was the monthly antibiotic use report run by the pharmacist, identified in November 2015, on the South East Wing, 3 residents were treated with antibiotics for UTI, on the North Wing, 2 residents were treated with antibiotics for UTI, and on the South West Wing, one resident was treated for UTI. Although the Continuous Quality Improvement, Monthly Resident Infection Statistics form for November 2015, indicated there were 8 resident UTI's, there was no corresponding documentation which indicated which residents were being tracked for UTI's, where they were located in the facility, what the microorganism was, and if the antibiotic was effective. During interview on 1/13/16, at 1:30 p.m. registered nurse (RN)-E, who was also in charge of the facility infection control program, stated the nurse managers met every morning and discussed resident infections. RN-E stated the pharmacist ran monthly antibiotic use reports 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.	21390		

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21390	Continued From page 14 Antibiotic monitoring. Maintenance of the employee health statistics records. Physician consultation." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies and procedures for infection control surveillance and data collection/analysis, and provide education to staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		

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

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

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	245517	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/14/2016

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on 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 from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	APPROVED By Tom Linhoff at 1:49 pm, Feb 12, 2016	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/12/16

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Oaklawn Health Care Center was constructed as follows:
The original building was constructed in 1964, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II (000) construction;
The 1995 building Addition is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 77 beds and had a census of 69 at time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. Findings include: On facility tour between 10:00 AM and 12:30 PM on 01/14/16, the review of the fire drill documentation for the past 12 months (January 2015 to December 2015) revealed the drills for the following shifts did not not sufficiently vary the times that the drills were conducted: a. day - 1st quarter @09:29 AM and 4th quarter @ 09:27AM b. night - 1st quarter @ 06:00 AM and 4th	K 050	1. Fire drills will be conducted by OHL Director at least quarterly on each shift, with variance of time (at least 90 minutes variance from previous fire drill on shift) and varying conditions. 2. Facility will be in compliance by February 23, 2016.	

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

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K 050	Continued From page 3 quarter @ 06:00 AM This deficient practice was confirmed by the Director of Facility Maintenance (NC) at the time of discovery.	K 050		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler 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 system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler 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 system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 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 sprinkler system. This deficient practice was confirmed by the	K 154	1. A separate policy has been developed for an automatic sprinkler system that is out of service for more than 4 hours in a 24 hour period. 2. Facility will be in compliance by February 11, 2016.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/14/2016

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

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K 154	Continued From page 4 Facility Maintenance Director (NC) at the time of discovery.	K 154		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 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.	K 155	1. A separate policy has been developed for the fire alarm system when it is out of service for more than 4 hours a 24 hour period. 2. Facility will be in compliance by February 11, 2016.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

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

Method of Correction and the Time Period For Correction.

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

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

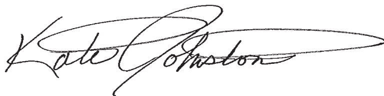
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division #212, St. Cloud MN, 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your 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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING: ____ B. WING ____	01/14/2016

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

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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 lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 1/11/2016-1/14/2016, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and

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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 must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: 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 daily 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."	2 565		

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2 565	Continued From page 2	2 565		

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, "A long 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

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2 565	Continued From page 3	2 565		

came back into R37's room with NA-G and they both began looking in R37's room for his top denture and it was located in R37's room. R37 slowly picked up his toothbrush from the sink, applied toothpaste with some difficulty, and began to brush his bottom natural teeth. NA-F returned to the bathroom and assisted R37 to finish brushing. NA-F brushed the top denture, applied denture adhesive, and placed the denture in R37's mouth. NA-F pushed R37 into the common area of the North wing, and placed him at the table for breakfast. R37 stated it felt good to have his teeth in and stated it had been a long time since he had them in.

Review of the Oral/Dental Evaluation dated 11/20/15, included R37 had a brand new upper full denture, and lower partial denture, and had several missing teeth. Also included, R37 had poor oral hygiene, and the summary noted, "Staff to remind/cue him to do oral cares and assist prn [as needed]. Resident is able to brush his own teeth with set up."

During interview on 1/13/16, at 2:26 p.m. registered nurse (RN)-D stated R37 occasionally refused oral cares and often took his dentures out of his mouth, however, staff should be offering and encouraging oral cares daily according to the residents plan of care.

R69's quarterly MDS dated 10/28/15, identified the resident had severe cognitive impairment had diagnosis including dementia and anxiety, and required extensive assist of one staff for personal hygiene including brushing his teeth and shaving.

R69's care plan dated 11/6/15, directed staff resident required assist of one with grooming

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2 565	Continued From page 4 including oral cares, and to set up resident to assist with washing face and hands and brushing teeth, and to provide assistance with oral cares morning, bedtime, and as needed. 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 was provided or offered to R69 during the observation. 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 was completed or offered to the resident, and NA-A stated she believed R69 was able to perform oral cares 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 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 offered every day, and should offer assistance or help as needed. 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 R69's care plan indicated assist of one staff for grooming and oral cares, and staff should be	2 565		

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2 565	Continued From page 5 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.	2 565		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		

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2 915	Continued From page 6	2 915		

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide assistance with grooming for 2 of 4 residents (R37, R69) who required staff assistance with personal hygiene.

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, updated 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."

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, "A long 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.

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2 915	Continued From page 7	2 915		

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 couldn't remember if she helped him to put his dentures in, and walked over to R37 and saw his dentures were not in. NA-F asked R37 if he wanted to put his teeth in and R37 stated, "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 checked the nursing assistant care sheet (which directs staff on resident cares) and stated, "It says he has upper and lower [dentures]." When she could not locate R37's top denture, NA-F stated she needed to ask for assistance, and left the room. While NA-F was gone, R37 asked, "Am I going to get to scrub my teeth today?" NA-F came back into R37's room with NA-G and they both began looking in R37's room for his top denture. R37 slowly picked up his toothbrush from the sink, applied toothpaste with some difficulty, and began to brush his bottom natural teeth. NA-F located R37's top denture in the residents room, returned to the bathroom, and assisted R37 to finish brushing. NA-F brushed the top denture, applied

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2 915	Continued From page 8	2 915		

denture adhesive, and placed the denture in R37's mouth. NA-F then pushed R37 into the common area of the North wing, and placed him at the table for breakfast. R37 stated it felt good to have his teeth in and stated it had been a long time since he had them in.

Review of dental hygiene progress notes from the Minneapolis Veteran's Administration dated 5/11/15, indicated R37 had moderate amounts of calculus and heavier amounts of plaque found throughout the remaining teeth. Also included, "Personal Oral Hygiene: poor. Patient needs to stay on each area for a longer amount of time. Needs to use daily proxy brush!"

Review of the Oral/Dental Evaluation dated 11/20/15, included R37 had a brand new upper full denture, and lower partial denture, and had several missing teeth. Also included, R37 had poor oral hygiene, and the summary noted, "Staff to remind/cue him to do oral cares and assist prn [as needed]. Resident is able to brush his own teeth with set up."

During an interview on 1/13/16, at 2:26 p.m. registered nurse (RN)-D stated R37 occasionally refused oral cares and often took his dentures out of his mouth, however, staff should be offering and encouraging oral cares daily.

R69's quarterly MDS dated 10/28/15, identified the resident had severe cognitive impairment had diagnosis including dementia and anxiety, and required extensive assist of one staff for personal hygiene including brushing his teeth and shaving.

R69's care plan dated 11/6/15, directed staff that resident required assist of one with grooming including oral cares, and to set up resident to

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2 915	Continued From page 9	2 915		

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

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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 offered every day, and should offer assistance or help as needed. Shaving was to be completed every day on males.

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 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 review or revise policies, and provide education for staff regarding resident grooming. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control	21390		

Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following:

A. surveillance based on systematic data

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21390	Continued From page 11 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 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:	21390		

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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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identified as "Nosocomial" infections. The corresponding Order Listing Report, which was the monthly antibiotic use report run by the pharmacist, identified in November 2015, on the South East Wing, 3 residents were treated with antibiotics for UTI, on the North Wing, 2 residents were treated with antibiotics for UTI, and on the South West Wing, one resident was treated for UTI. Although the Continuous Quality Improvement, Monthly Resident Infection Statistics form for November 2015, indicated there were 8 resident UTI's, there was no corresponding documentation which indicated which residents were being tracked for UTI's, where they were located in the facility, what the microorganism was, and if the antibiotic was effective.

During interview on 1/13/16, at 1:30 p.m. registered nurse (RN)-E, who was also in charge of the facility infection control program, stated the nurse managers met every morning and discussed resident infections. RN-E stated the pharmacist ran monthly antibiotic use reports 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.

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21390	Continued From page 14 Antibiotic monitoring. Maintenance of the employee health statistics records. Physician consultation." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies and procedures for infection control surveillance and data collection/analysis, and provide education to staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		