*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
October 2, 2023

Administrator
Oaklawn Care & Rehabilitation Center
201 Oaklawn Avenue
Mankato, MN  56001

RE: CCN: 245517
Cycle Start Date: June 15, 2023

Dear Administrator:

On August 17, 2023, we notified you a remedy was imposed. On August 23, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 11, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 21, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 15, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 11, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

*Protecting, Maintaining and Improving the Health of All Minnesotans*

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July 17, 2023

Administrator
Oaklawn Care & Rehabilitation Center
201 Oaklawn Avenue
Mankato, MN  56001

RE: CCN: 245517
Cycle Start Date: June 15, 2023

Dear Administrator:

On June 15, 2023, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC 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.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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 September 15, 2023, (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).

In addition, if substantial compliance with the regulations is not verified by December 15, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

| 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 _____ | C 06/15/2023 |

| 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 |
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| E 000 | Initial Comments<br><br>On 6/12/23-6/15/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained. | E 000 | | |
| E 039 SS=C | EP Testing Requirements<br>CFR(s): 483.73(d)(2)<br><br>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).<br><br>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is | E 039 | | 8/15/23 |

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

Electronically Signed | 07/31/2023

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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| E 039 | Continued From page 1<br>community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.<br>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For Hospices at 418.113(d):]<br>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or | E 039 | | |

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| E 039 | Continued From page 2<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from | E 039 | | |

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| E 039 | Continued From page 3<br>engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the | E 039 | | |

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| E 039 | Continued From page 4<br>onset of the emergency event.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 | E 039 | | |

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| E 039 | Continued From page 5<br>years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.<br><br>*[For LTC Facilities at §483.73(d):]<br>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that | E 039 | | |

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| E 039 | Continued From page 6<br>may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or | E 039 | | |

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| E 039 | Continued From page 7<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is | E 039 | | |

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| E 039 | Continued From page 8<br>led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.<br>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group | E 039 | | |

| 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 _____ | C 06/15/2023 |

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

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| E 039 | Continued From page 9<br>discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure two emergency preparedness (EP) exercises, including two full-scale community based exercises, or one community based exercise and a table top exercise, or had activated their plan as a result of a actual event, were completed annually to test their EP program. This had the potential to affect all 44 residents residing at the facility.<br><br>Findings include:<br><br>On 6/13/23 at 2:16 p.m., the administrator stated EP responsibilities related to the full-scale exercise, table-top or actual event were the administrators responsibility. The administrator stated the former administrator recently left the facility, and that no documented EP drills had been conducted in 2022 or 2023. neither a full-scale exercise, table-top or actual event.<br><br>The facility Community and Facility exercise/drill Emergency Disaster Plans policy undated, indicated:<br>Facility must participate in a full scale exercise that is community based or when community based exercise is not accessible and individual, facility based. If the a facility experiences an | E 039 | Plan of Correction□E039<br><br>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.<br><br>How corrective action will be taken for those affected by the alleged deficient practice:<br><br>¿The facility has a table top and full scale exercise planned for 8/15/2023 or sooner.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents have the potential to be affected by the alleged deficiency.<br><br>The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: | |

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|---|---|---|---|---|
| E 039 | Continued From page 10<br>actual natural or man-made emergency that requires activation of the emergency plan the facility is exempt from engaging in a community based or individual facility based full scale exercise for 1 year following the onset of the actual event. Facility must conduct an additional exercise that may include but is not limited to the following:<br>o A second full scale exercise that is community based or individual facility based.<br>o A tabletop exercise that includes a group discussion led by a facilitator, using narrated clinically-relevant emergency scenario and a set of problem statements,a directed messages or prepared questions designated to challenge an emergency plan.<br>o Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the facility's emergency plan as needed. | E 039 | Regional Director of Operations will complete education with the facility's new Administrator regarding the implementation of full scale and table top drills.<br><br>Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent:<br><br>Admin will review drills in monthly QAPI<br><br>Completion date: 8/15/2023 | |
| E 041 SS=F | Hospital CAH and LTC Emergency Power<br>CFR(s): 483.73(e)<br><br>§482.15(e) Condition for Participation:<br>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.<br><br>§483.73(e), §485.625(e), §485.542(e)<br>(e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. | E 041 | | 8/15/23 |

| 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 _____ | C 06/15/2023 |

| 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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|---|---|---|---|---|
| E 041 | Continued From page 11<br>§482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)<br>Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)<br>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):]<br>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. | E 041 | | |

| 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 _____ | C 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| E 041 | Continued From page 12<br>552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including | E 041 | | |

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|---|---|---|---|
| | 245517 | A. BUILDING _____ B. WING _____ | C 06/15/2023 |

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|---|---|---|---|---|
| E 041 | Continued From page 13<br>TIAs to chapter 7, issued August 6, 2009..<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide emergency generator testing in accordance with the 2012 Edition of Life Safety Code (NFPA 101), section 9.1.3.1, and the 2010 Edition of NFPA 110, Standard for Emergency and Standby Power Systems.<br><br>Findings include:<br><br>On 06/14/2023 between 9:30 a.m. and 1:30 p.m., it was revealed during documentation review that no 36 month - 4 hour load bank documentation was presented for review.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | E 041 | Plan of Correction—E041<br><br>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.<br><br>How corrective action will be taken for those affected by the alleged deficient practice:<br><br>The facility had the 4 hour load bank tested on 6/15/23<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents have the potential to be affected by the alleged deficiency.<br><br>The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:<br><br>Administrator will educate Maintenance director regarding completing appropriate testing.<br><br>Quality Assurance ,plans to monitor facility performance to make sure that | |

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|---|---|---|---|
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|---|---|---|---|---|
| E 041 | Continued From page 14 | E 041 | corrections are achieved and are permanent:<br><br>Maintenance director will review upcoming and overdue testing during QAPI.<br><br>Completion date: 8/15/2023 | |
| F 000 | INITIAL COMMENTS<br><br>On 6/12/23-6/15/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>In addition to the recertification survey, the following complaints were reviewed<br><br>The following complaints were reviewed with no deficiency issued.<br>H55172640C (MN00093765) (MN00093770)<br>H55172722C (MN00087523)<br>H55172723C (MN00088525)<br>H55172724C (MN00089984)<br>H55172884C (MN00094511)<br><br>The following complaints were reviewed.<br>H55172641C (MN00090582) with a deficiency issued at (F624 and F657)<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will | F 000 | | |

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|---|---|---|---|
| | 245517 | A. BUILDING _____ B. WING _____ | C 06/15/2023 |

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|---|---|
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|---|---|---|---|---|
| F 000 | Continued From page 15<br>be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced | F 609 | | 8/15/23 |

| 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 _____ | C 06/15/2023 |

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|---|---|---|---|---|
| F 609 | Continued From page 16<br>by:<br>Based on interview and document review, the facility failed to ensure allegations of abuse/neglect were reported to the (SA) within 2 hours, in accordance with established policies and procedures, for 1 of 1 residents (R21) reviewed for allegations of resident to resident verbal abuse.<br><br>Findings include:<br><br>R21's quarterly Minimum Data Set (MDS) assessment dated 3/21/23, identified R21 had intact cognition, required total dependence of 2 staff for transfers, limited assistance of 1 staff for locomotion on and off unit, and used a wheelchair for mobility needs. Diagnoses included depression.<br><br>R21's care plan dated 7/21/22, indicated for staff to be aware of statements or signs/symptoms of abuse. If they are present, update medial director (MD), DON, and administrator immediately; staff will continue to follow the facility vulnerable adult & abuse reporting policy; the local Ombudsman, Adult Protection, Police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed.<br><br>R25's significant change in status MDS assessment dated 3/14/23, identified R25 had intact cognition, required total dependence of 2 staff for transfers, limited assistance of 1 staff for locomotion on and off unit, and used a wheelchair for mobility needs. Diagnoses included dementia, anxiety, and depression.<br><br>R25's care plan dated 7/7/22, indicated for staff to provide supervision as needed, be alert to mood | F 609 | Plan of Correction—F609<br><br>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.<br><br>How corrective action will be taken for those affected by the alleged deficient practice:<br><br>àThe facility reported and initiated an investigation on 6/14/2023, and did not determine that abuse occurred.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents have the potential to be affected by the alleged deficiency.<br><br>The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:<br><br>RDO-A filed an OHFC report with state agency on 6/14/23<br><br>Facility implemented increased supervision with top of the hour checks for both residents.<br><br>Facility interviewed all LTC residents to identify other or related allegations of | |

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|---|---|---|---|---|
| F 609 | Continued From page 17<br>and behavioral changes, monitor and document mood state/behaviors upon occurrence, monitor safety concerns. R25's care plan dated 7/12/22, indicated for staff to be aware of statements or signs/symptoms of abuse. If they are present, update MD, DON, and administrator immediately; staff will continue to follow the facility vulnerable adult & abuse reporting policy, the local Ombudsman, Adult Protection, Police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed, inform MD of changes in mood state.<br><br>During an interview, on 6/12/23 at 6:23 p.m., R21 reported allegations of being verbally abused per R25 during an incident that had occurred approximately 3 months ago. R21 stated R25 approached her while she was sitting in a recliner chair in the south hall dayroom, R25 became verbally abusive towards her stating, "get out of my ... [profanity used] chair." R21 indicated she was upset by the incident and immediately reported the event to the director of nursing (DON)-E. R21 stated she felt uncared for by staff following the incident, reported DON-E indicated R21 needed to be more understanding of R25's lack of control with behaviors due to R25's medical condition.<br><br>R21's medical record was reviewed and lacked any recorded evidence or details related to an allegation of resident-to-resident verbal abuse with R25.<br><br>R25's medical record was reviewed and lacked any recorded evidence or details related to an allegation of resident-to-resident verbal abuse with R21. | F 609 | abuse by other residents. No other allegations of abuse were made.<br><br>RDO-A will educate new administrator regarding abuse reporting and investigations.<br><br>Administrator will educate staff on abuse reporting and investigations.<br><br>Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent:<br><br>Admin or designee will complete audits 5x per week for 2 weeks (or as grievances allow)<br><br>Completion date: 8/15/2023 | |

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|---|---|---|---|---|
| F 609 | Continued From page 18 | F 609 | | |

Facility incident reports reviewed and lacked any recorded evidence or details related to an allegation of resident -to-resident verbal abuse between R21 and R25.

When interviewed, on 6/14/23 at 12:38 p.m., trained medication aide (TMA)-A indicated awareness R25 will occasionally swear or yell when became frustrated, not aware of R25 being physically or verbally abusive towards other residents or staff. TMA-A stated when R25 becomes frustrated, staff provide redirection, try to figure out what R25 is wanting, will get licensed nurse to reapproach, occasionally contact R25's spouse as she was able to calm R25 easily.

During an interview, on 6/14/23 at 1:39 p.m., registered nurse (RN)-E indicated R21 reported to her 4 days ago an incident had occurred between R21 and R25. R21 informed RN-E while R21 was sitting in day room, R25 started swearing at R21 for no reason in front of other residents. RN-E was unaware of when the incident between R21 and R25 occurred, R21 indicated to RN-E she had reported event to DON-E immediately following incident, R21 stated to RN-E social services (SS) also aware of incident.

While interviewed, on 6/14/23 at 3:23 p.m., SS-A indicated she had received grievance form from R21 on 6/12/23 regarding and incident that had occurred a couple of months ago, between R21 and R25. SS-A stated R21 indicated while sitting in recliner chair in day room, R25 became upset and told R21 to get out of his chair. SS-A indicated R25 had dementia and forgot at times his spouse donated recliner chair in south day room for all residents to use. SS-A stated staff

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| F 609 | Continued From page 19<br>have tried re-educating R25 of chair donated per spouse, sometimes R21 was ok with letting other residents sit in recliner chair, other times R21 would become upset and not want other residents sitting in chair. SS-A indicated when she had had received the grievance form from R21 on 6/12/23, she had met with R21 the same day to discuss the incident and R21's concerns. SS-A indicated she had not filed a VA report after speaking with R21 on 6/12/23, stated incident occurred a couple of months ago and R21 had already reported incident to DON-E, SS-A needed to further investigate what follow-up had been completed per DON-E.<br><br>During an interview, on 6/14/23 at 4:11 p.m., RN-A and DON indicated unawareness of any abuse allegations reported per R21, needed to further investigate. RN-A stated staffing had changed recently at time of survey, had regional director of operations (RDO) in administrator position, DON in training for approximately 1 month.<br><br>While interviewed, on 6/14/23 at 4:30 p.m., RDO-A indicated SS-A just notified him of grievances she had received on 6/12/23 per R21, RDO-A unaware of any abuse allegations involving R21 and needed to investigate further into matter. RDO-A stated he would file a vulnerable adult (VA) report if needed after obtaining more information regarding incident, indicated all staff had been properly educated on s/s of abuse and when to report.<br><br>While interviewed, on 6/15/23 at 8:50 a.m., RDO-A indicated further follow-up into R21's allegations of verbal abuse per R25. RDO-A had spoken with DON-E on 6/14/23 per telephone | F 609 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245517 | A. BUILDING _____ B. WING _____ | C 06/15/2023 |

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| F 609 | Continued From page 20<br>communication, DON-E had indicated she did not file a VA report and should have after R21 reported to her allegations of verbal abuse per R25. RDO-A indicated immediately following phone conversation with DON-E on 6/14/23, RDO-A filed VA report with State agency, indicated R21's allegations of verbal abuse per R25 should have been reported to State agency immediately awareness of incident.<br><br>On 6/15/23 at 9:08 a.m., a phone conversation was attempted with DON-E, left message to return call, no return call.<br><br>The facility Abuse Prohibition/Vulnerable Adult Plan policy revised 2/2/23, directed; Purpose: 1. To ensure that residents are not subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other<br>individuals, or self-abuse.<br>2. To ensure that all incidents of alleged or suspected abuse/neglect are promptly reported and then investigated.<br>4. To identify and remedy any abusive situations. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, | F 610 | | 8/15/23 |

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| F 610 | Continued From page 21<br>neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure allegations of abuse were thoroughly investigated and provide for immediate protection along with systemic correction in a timely manner to prevent further incidents for 1 of 1 resident (R21) who reported allegations of resident-to-resident verbal abuse to the facility.<br><br>Findings include:<br><br>R21's quarterly Minimum Data Set (MDS) assessment dated 3/21/23, identified R21 had intact cognition, required total dependence of 2 staff for transfers, limited assistance of 1 staff for locomotion on and off unit, and used a wheelchair for mobility needs. Diagnoses included depression.<br><br>R21's care plan dated 7/21/22, indicated for staff to be aware of statements or signs/symptoms of abuse. If they are present, update medial director (MD), DON, and administrator immediately; staff will continue to follow the facility vulnerable adult & abuse reporting policy; the local Ombudsman, Adult Protection, Police, and/or state/financial agencies will be notified of any suspected abuse | F 610 | Plan of Correction—F610<br><br>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.<br><br>How corrective action will be taken for those affected by the alleged deficient practice:<br><br>The facility reported and initiated an investigation on 6/14/2023, and did not determine that abuse occurred.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents have the potential to be affected by the alleged deficiency.<br><br>The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not | |

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| F 610 | Continued From page 22<br>or financial exploitation as needed.<br><br>R25's significant change in status MDS assessment dated 3/14/23, identified R25 had intact cognition, required total dependence of 2 staff for transfers, limited assistance of 1 staff for locomotion on and off unit, and used a wheelchair for mobility needs. Diagnoses included dementia, anxiety, and depression.<br><br>R25's care plan dated 7/7/22, indicated for staff to provide supervision as needed, be alert to mood and behavioral changes, monitor and document mood state/behaviors upon occurrence, monitor safety concerns. R25's care plan dated 7/12/22, indicated for staff to be aware of statements or signs/symptoms of abuse. If they are present, update MD, DON, and administrator immediately; staff will continue to follow the facility vulnerable adult & abuse reporting policy, the local Ombudsman, Adult Protection, Police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed, inform MD of changes in mood state.<br><br>During an interview, on 6/12/23 at 6:23 p.m., R21 reported allegations of being verbally abused per R25 during an incident that had occurred approximately 3 months ago. R21 stated R25 approached her while she was sitting in a recliner chair in the south hall dayroom, R25 became verbally abusive towards her stating, "get out of my ... [profanity used] chair." R21 indicated she was upset by the incident and immediately reported the event to the director of nursing (DON)-E. R21 stated she felt uncared for by staff following the incident, reported DON-E indicated R21 needed to be more understanding of R25's lack of control with behaviors due to R25's | F 610 | occur:<br><br>RDO-A filed an OHFC report with state agency on 6/14/23<br><br>Facility implemented increased supervision with top of the hour checks for both residents.<br><br>Facility interviewed all LTC residents to identify other or related allegations of abuse by other residents. No other allegations of abuse were made.<br><br>RDO-A will educate new administrator regarding abuse reporting and investigations.<br><br>Administrator will educate staff on abuse reporting and investigations.<br><br>Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent:<br><br>Admin or designee will complete audits 5x per week for 2 weeks (or as grievances allow)<br><br>Completion date: 8/15/2023 | |

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| F 610 | Continued From page 23<br>medical condition.<br><br>R21's medical record was reviewed and lacked any recorded evidence or details related to an allegation of resident-to-resident verbal abuse with R25.<br><br>R25's medical record was reviewed and lacked any recorded evidence or details related to an allegation of resident-to-resident verbal abuse with R21.<br><br>Facility incident reports reviewed and lacked any recorded evidence or details related to an allegation of resident -to-resident verbal abuse between R21 and R25.<br><br>When interviewed, on 6/14/23 at 12:38 p.m., trained medication aide (TMA)-A indicated awareness R25 will occasionally swear or yell when became frustrated, not aware of R25 being physically or verbally abusive towards other residents or staff. TMA-A stated when R25 becomes frustrated, staff provide redirection, try to figure out what R25 is wanting, will get licensed nurse to reapproach, occasionally contact R25's spouse as she was able to calm R25 easily.<br><br>During an interview, on 6/14/23 at 1:39 p.m., registered nurse (RN)-E indicated R21 reported to her 4 days ago an incident had occurred between R21 and R25. R21 informed RN-E while R21 was sitting in day room, R25 started swearing at R21 for no reason in front of other residents. RN-E was unaware of when the incident between R21 and R25 occurred, R21 indicated to RN-E she had reported event to DON-E immediately following incident, R21 stated to RN-E social services (SS) also aware of | F 610 | | |

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| F 610 | Continued From page 24<br>incident. RN-E indicated unawareness of investigation results or if any interventions were put into place following incident.<br><br>While interviewed, on 6/14/23 at 3:23 p.m., SS-A indicated she had received grievance form from R21 on 6/12/23 regarding and incident that had occurred a couple of months ago, between R21 and R25. SS-A stated R21 indicated while sitting in recliner chair in day room, R25 became upset and told R21 to get out of his chair. SS-A indicated R25 had dementia and forgot at times his spouse donated recliner chair in south day room for all residents to use. SS-A stated staff have tried re-educating R25 of chair donated per spouse, sometimes R21 was ok with letting other residents sit in recliner chair, other times R21 would become upset and not want other residents sitting in chair. SS-A indicated when she had had received the grievance form from R21 on 6/12/23, she had met with R21 the same day to discuss the incident and R21's concerns. SS-A indicated she had not filed a VA report after speaking with R21 on 6/12/23, stated incident occurred a couple of months ago and R21 had already reported incident to DON-E, SS-A needed to further investigate what follow-up had been completed per DON-E.<br><br>During an interview, on 6/14/23 at 4:11 p.m.., RN-A and DON-B indicated unawareness of any recent abuse allegations per R25 reported per R21. RN-A stated staffing had changed recently at time of survey, had regional director of operations (RDO) in administrator position, DON-B in training for approximately 1 month. RN-A and DON-B indicated unawareness of any recent investigation reports or interventions implemented involving abuse allegations between | F 610 | | |

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| F 610 | Continued From page 25<br>R21 and R25, both RN-A and DON-B stated need to investigate further into incident.<br><br>While interviewed, on 6/14/23 at 4:30 p.m., RDO-A indicated SS-A just notified him of grievances she had received on 6/12/23 per R21, RDO-A unaware of any abuse allegations involving R21 and needed to investigate further into matter. RDO-A stated he would file a vulnerable adult (VA) report if needed after obtaining more information regarding incident, indicated all staff had been properly educated on s/s of abuse and when to report.<br><br>While interviewed, on 6/15/23 at 8:50 a.m., RDO-A indicated further follow-up into R21's allegations of verbal abuse per R25. RDO-A had spoken with DON-E on 6/14/23 per telephone communication, DON-E had indicated she did not file a VA report and should have after R21 reported to her allegations of verbal abuse per R25. RDO-A indicated immediately following phone conversation with DON-E on 6/14/23, RDO-A filed VA report with State agency and started investigation into incident.<br><br>On 6/15/23 at 9:08 a.m., a phone conversation was attempted with DON-E, left message to return call, no return call.<br><br>The facility Abuse Prohibition/Vulnerable Adult Plan policy revised 2/2/23, directed; Purpose: 1. To ensure that residents are not subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other<br>individuals, or self-abuse. | F 610 | | |

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| F 610 | Continued From page 26<br>2. To ensure that all incidents of alleged or suspected abuse/neglect are promptly reported and then investigated.<br>4. To identify and remedy any abusive situations. | F 610 | | |
| F 624 SS=D | Preparation for Safe/Orderly Transfer/Dschrg<br>CFR(s): 483.15(c)(7)<br><br>§483.15(c)(7) Orientation for transfer or discharge.<br>A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to safely discharge 1 of 1 resident (R96), whose discharged medications included another resident medication.<br><br>Findings include:<br><br>R96's discharge Minimal Data Set (MDS) assessment dated 1/11/23, indicated diagnoses included pneumonia, hypertension, tachycardia, heart failure, acute respiratory failure, and age-related debility.<br><br>R96's document titled Rounds for Mayo dated 1/9/23, indicated OK to discharge with current medications and treatments, and OK for 30-day supply of medications.<br><br>R96's document titled Discharge Record dated 1/11/23, by licensed practical nurse (LPN)-A indicated resident was discharge home on | F 624 | Plan of Correction—F624<br><br>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.<br><br>How corrective action will be taken for those affected by the alleged deficient practice:<br><br>àR96 has discharged from the facility and the medication card was returned to the facility.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice? | 8/15/23 |

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| F 624 | Continued From page 27<br>1/11/23 at 11:00 a.m.<br><br>R96's record review indicated no information regarding R96 discharge medication error.<br><br>On 6/14/23 at 11:18 a.m., during a phone interview family member (FM)- A stated on 1/11/23, R96 was discharged home from the facility with another resident's medication card. FM-A stated the medication cards were not reviewed by the facility staff at the time of discharge. FM-A stated on 1/11/23, she notified LPN-A via a telephone call regarding the medication card sent home with R96. FM-A stated LPN-A stated the medication card could be returned to the facility or discarded. FM-A stated the next day the mediation card was returned to the facility and verified the medication was pramipexole (medication used to treat Parkinson's and restless leg syndrome). FM-A stated concern if R96 would have received the wrong medication.<br><br>On 6/14/23 at 11:41 a.m., LPN-A confirmed she completed R96's discharge paperwork and medications. LPN-A confirmed R96 was sent home with another resident's medication card, and stated discharge medications were reviewed with FM-A prior to R96's discharge and would not expect another resident's mediation sent home with R96. LPN-A stated FM-A called and notified her R96 received another resident's medication card. LPN-A stated she could not remember if an incident report was filed, or the director of nursing was notified. LPN-A stated no procedures had changed since the incident.<br><br>On 6/14/23 at 1:00 p.m., registered nurse (RN)-A the regional nurse consultant verified an incident | F 624 | All residents have the potential to be affected by the alleged deficiency.<br><br>The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:<br><br>DON or designee will educate all nurses on verifying medications upon discharge.<br><br>Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent:<br><br>DON or designee will complete audits 5x per week for 2 weeks (or as grievances allow)<br><br>Completion date: 8/15/2023 | |

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| F 624 | Continued From page 28<br>report or education was not done with nursing following the wrong medication card sent home with R96. RN-A stated facility expectations and good practice was to review the medications and confirm the correct medication cards were sent home with residents on discharge. RN-A stated facility would expect the incident "looked" into and education to the nurse to prevent future occurrences.<br><br>The facility Discharge Planning policy dated 11/16, directed the purpose of discharge conferences is to provide all parties involved the opportunity to review the resident's progress while at the facility, his/her strengths and weaknesses, and Post Discharge of Resident community resources available to maintain or improve goals achieved, and to Determine a specific date and time for discharge. Arrange transportation to discharge destination. Provide or arrange for specific instructions or teaching for resident and family. Arrange for medications, supplies, equipment required. | F 624 | | |
| F 657 SS=B | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident. | F 657 | | 8/15/23 |

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| F 657 | Continued From page 29<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure nursing staff had been in attendance at care conferences conducted for 3 of 3 residents (R3, R28, R96 ) reviewed for care planning.<br><br>Findings include:<br><br>R28's facesheet printed on 6/15/23 included diagnoses of rhabdomyolysis (breakdown of muscle tissue), pressure ulcers and repeated falls.<br><br>R28's significant change Minimum Data Set (MDS) assessment dated 4/20/23, indicated R28 was cognitively intact; had clear speech, was understood and could understand. R28 did not walk and required extensive assistance of one or two staff for activities of daily living.<br><br>R28's care plan with multiple dates since admission on 3/14/23, included discharge | F 657 | Plan of Correction F657<br><br>How corrective action will be taken for those affected by the alleged deficient practice:<br><br>Residents R3, R28 and R96 will have a nurse review their plan of care with themselves and/or their responsible party.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents in the facility will have a scheduled care conference that is attended by a nurse who will be able to review the residents' plan of care.<br><br>The measures the facility will take or | |

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| F 657 | Continued From page 30<br>planning, falls, behaviors, mobility, toileting, pain, skin and wound care -- all areas which would be evaluated by nursing staff.<br><br>During an interview on 6/12/23 at 4:56 p.m., R28 stated she was not familiar with care conferences and had never attended one.<br><br>During record review, a progress note dated 3/27/23, indicated R28 had a care conference that day and to refer to the IDT (interdisciplinary team) care conference form for notes. A form titled IDT Care Conference in the electronic medical record (EMR) indicated a care conference had been conducted on 3/27/23, with R28 in attendance, however a nurse did not attend. Disciplines in attendance had been therapeutic recreation, dietary and social services. The section of the care conference notes to have been completed by a nurse were blank and included:<br>-- Type of care conference being conducted (admission, quarterly, annual, or significant change)<br>-- Medication assessment<br>-- Physical restraints<br>-- Falls risk<br>-- Positioning<br>-- Exams (dental and eye)<br>-- Bowel and bladder, and bathing preferences<br>-- Immunizations<br>-- IDT care conference summary<br>-- Nurse signature and date<br><br>During an interview on 6/15/23 at 7:58 a.m., registered nurse (RN)-A who was also the regional nurse consultant, stated she had not been aware until the day before -- 6/14/23, that nursing had not attended all care conferences. | F 657 | systems the facility will alter to ensure that the problem will be corrected and will not occur:<br><br>Social Services will audit nurse leadership attendance for every care conference that occurs. If a nurse manager fails or is unable to attend a care conference, the assigned nurse manager must be replaced by another nurse who is able to attend and review the residents plan of care.<br><br>The facility nurse leadership team will be educated on the facilities expectation and state regulation them to attend resident care conferences to review care planning<br><br>Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent:<br><br>Administrator or designee will audit nurse leadership care conference attendance every week for x2 weeks<br><br>Completion date: 8/15 | |

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| F 657 | Continued From page 31<br>Except in a rare circumstance, such as needing to provide resident care on short notice, RN-A would have expected a nurse manager to attend care conferences, or to have completed the nursing section of the care conference form prior to the scheduled care conference. RN-A stated the facility did not have a policy on care conferences.<br>R3's face sheet dated 6/15/23, indicated admitted 12/29/18, diagnoses included type 1 diabetes, schizophrenia, borderline personality disorder, chronic pain, heart failure, edema, and major depressive disorder.<br><br>R3's annual MDS assessment dated 5/23/23, indicated R3 was cognitively intact, no behaviors, required set up help with bed mobility, transfer, eating, toilet use, one person physical assist with dressing, personal hygiene, extensive assistance of one or two staff for activities of daily living.<br><br>R3's care plan dated 3/13/18, indicated discharge planning would occur with social services, nurse manager, interdisciplinary team and nursing.<br><br>Record review failed to indicate nursing was in attendance during the last three care conferences dated 6/7/23, 3/6/23, or 12/12/22.<br><br>Form titled IDT Care Conference in the electronic medical record (EMR) indicated a care conference had been conducted on 6/7/23, 3/6/23, or 12/12/22, with R28 in attendance, however a nurse did not attend. The nurse section of the care conference form was blank included:<br>-- Type of care conference being conducted (admission, quarterly, annual, or significant change) | F 657 | | |

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| F 657 | Continued From page 32<br>-- Medication assessment<br>-- Physical restraints<br>-- Falls risk<br>-- Positioning<br>-- Exams (dental and eye)<br>-- Bowel and bladder/bathing<br>-- Immunizations<br>- IDT care conference summary<br>- Nurse signature and date<br><br>R96's face sheet dated 6/15/23, indicated resident was admitted on 12/20/22 and discharged 1/11/23.<br><br>R96's discharge MDS assessment dated 1/11/23, indicated diagnoses included pneumonia, hypertension, tachycardia, heart failure, acute respiratory failure, and age-related debility.<br><br>R96's record review failed to indicate nursing was in attendance for R96's care conference on 1/3/23.<br><br>R96's form titled IDT Care Conference in the electronic medical record (EMR) indicated an admission care conference had been conducted on 1/3/23, however a nurse did not attend. The nurse section of the care conference form was blank included:<br>-- Type of care conference being conducted (admission, quarterly, annual, or significant change)<br>-- Medication assessment<br>-- Physical restraints<br>-- Falls risk<br>-- Positioning<br>-- Exams (dental and eye)<br>-- Bowel and bladder/bathing<br>-- Immunizations | F 657 | | |

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| F 657 | Continued From page 33<br>- IDT care conference summary<br>- Nurse signature and date<br><br>On 6/14/23 at 11:07 a.m., social services (SS)-A stated R96 last care conference on 1/3/23, was attended by social services and activities and stated and verified nursing was not in attendance. SS confirmed nursing was expected at resident care conferences.<br><br>On 6/14/23 at 11:41 a.m., LPN-A stated nursing was expected at residents care conferences, and verified on R96's care conference on 1/3/23, a nurse was not present or completed the EMR IDT care conference form.<br><br>On 6/15/23 at 10:33 a.m., RN-A verified nursing had not attended R3's last three IDT care conferences. RN-A confirmed the last care conferences for R3, R28, and R96 were not attended by nursing and verified the facility expectations of the care conference IDT form and assessments were not completed. RN-A stated the nurse mangers were expected to attend the residents care conference and follow the RAI (Resident Assessment Instrument) process. RN-A stated she talked with nurse managers LPN-A and RN-C and they confirmed the process. RN-A stated if a nurse manager was not able to attend another nurse was expected at the IDT care conference. RN-A stated the care conferences were scheduled by social services and during the daily morning meeting the care conferences scheduled for the day were reviewed and discussed with nurse managers. RN-A stated LPN-A had not attended care conferences due to shortage of time and other nurse manager duties, LPN-A confirmed she knew of the care conferences and was expected to attend. RN-A | F 657 | | |

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| F 657 | Continued From page 34<br>stated the interdisciplinary team were expected to use the IDT form in the EMR and the staff were expected to follow the form in the EMR and all disciplines were expected to fill out the designated sections.<br><br>Policy on care conferences requested but not provided as no policy available. | F 657 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to implement the bowel movement (BM) protocol for 1 of 1 resident (R11) reviewed for constipation.<br><br>Findings include:<br><br>R11's facesheet printed on 6/15/23 indicated diagnoses of end stage renal disease, diabetes, and obesity.<br><br>R11's admission Minimum Data Set (MDS) assessment dated 5/8/23, indicated R11 was cognitively intact, had clear speech, was understood and able to understand. R11 did not walk and required extensive assistance or was | F 684 | Plan of Correction<br><br>How corrective action will be taken for those affected by the alleged deficient practice:<br><br>R11□s care plan and orders have been updated to reflect the facility□s bowel management program.<br><br>How will the facility identify other residents having the potential to be affected by the | 8/15/23 |

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| F 684 | Continued From page 35<br>totally dependent on two staff for activities of daily living, including toileting. R11 was always incontinent of stool.<br><br>R11's physician orders dated 5/2/23, included a stool softener laxative, Sennosides-Docusate Sodium, two tablets to be given by mouth every 12 hours as needed for constipation. According to R11's MAR (medication administration record), this medication had not been given in May or June. In addition, an order dated 5/2/23 included the use of Standing Orders (written protocols authorizing a nurse to complete a task without first obtaining a physician order).<br><br>Facility document titled Routine Standing Orders indicated the following constipation medications. Instructions indicated staff were to notify a provider if symptoms persisted more than 48 hours:<br>--Senokot-S one tab(let) oral twice daily PRN (as needed) for constipation<br>--Milk of Magnesia (a laxative) 30 cc (cubic centimeters) oral daily if no bowel movement for two days<br>--Dulcolax suppository (a stimulant laxative) one PR (per rectum) daily PRN if no bowel movement for 3 days<br>--Fleet or tap water enema rectally daily PRN constipation<br><br>R11's care plan did not address elimination of bowels or constipation.<br><br>During an interview on 6/12/23 at 5:58 p.m., R11 stated he was six days out since his last BM. R11 stated he had told nursing staff this (could not recall who). R11 stated when given stool softeners, it caused diarrhea which was a | F 684 | same deficient practice?<br><br>All residents have the potential to be affected by alleged deficient practice.<br><br>The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:<br><br>Nursing has been educated on completing the bowel management protocol. Any residents w/o bowel movements for three days are reviewed in morning meeting.<br><br>Facility reviewed and audited all residents to make insure appropriate bowel protocol.<br><br>Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent:<br><br>DON or designee will complete 5 audits weekly for two weeks<br><br>Completion date: 8/15/2023 | |

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| F 684 | Continued From page 36<br>concern as he attended dialysis three times a week and did not want diarrhea stools when he was at the dialysis facility.<br><br>The following BM information was provided by the administrator via email on 6/13/23 at 2:38 p.m.<br>R11 who had been admitted on 5/2/23 had gone three to seven days between some BM's:<br>No BM for three days: 5/3/23 to 5/7/23<br>No BM for seven days: 5/8/23 to 5/16/23<br>No BM for four days: 6/6/23 to 6/11/23<br><br>During an interview on 6/14/23 at 9:58 a.m., registered nurse (RN)-B stated the night shift nurse was supposed to run a BM report from the EMR (electronic medical record) and provide a medication intervention using either the residents physician orders or facility standing orders when a resident had gone more than two days without a BM. RN-B stated the night shift nurse did not consistently run the report and felt this was due to inconsistent nursing staff working the night shift -- a combination of employed staff and agency staff. RN-B admitted she relied on the night shift nurse to run the report and was not aware R11 reportedly had gone six days without a BM.<br><br>During an interview on 6/14/23 at 1:16 p.m., RN-C reviewed the BM information provided by the administrator and acknowledged the length of time between some BM's were greater than two and three days. RN-C stated an "overnight task" for the night nurse was to run a BM report and identify those residents who had not had a BM for two days, then the day shift nurse was to provide the intervention. RN-C stated if the night nurse had not run the report, she expected the day shift nurse to run the report. Together reviewed the facility standing orders for BM protocol which | F 684 | | |

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|---|---|---|---|
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| F 684 | Continued From page 37<br>indicated specific medication interventions for constipation. RN-C stated the reason the residents were not being identified could be due to agency staff working the night shift and not knowing they were supposed to run the BM report, or staff not knowing how to run the BM report. RN-C provided a blank copy of a night shift task list which was a monthly list identifying 28 items to perform, including "BM List." There had not been a working copy of this list implemented and/or started for the month of June. RN-C stated this task list had not been a part of the night shift nurse orientation but would be added now.<br><br>During an interview on 6/15/23 at 7:58 a.m., (RN)-A who was also the regional nurse consultant and the director of nursing (DON) were informed of the number of days R11 went without a BM. RN-A stated there wasn't a policy on monitoring BM's, but standing orders were the guidance the nursing staff should be following. | F 684 | | |
| F 698 SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to consistently monitor and assess a resident for potential complications related to dialysis treatment and failed to ensure consistent communication with the dialysis facility for 1 of 1 | F 698 | Plan of Correction F698<br><br>How corrective action will be taken for | 8/15/23 |

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|---|---|---|---|
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|---|---|
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| F 698 | Continued From page 38<br>resident (R11) reviewed for dialysis.<br><br>Findings include:<br><br>R11's facesheet printed on 6/15/23, included diagnoses of end stage renal disease and dependence on renal dialysis (a treatment for failing kidneys to remove fluid and waste from the blood).<br><br>R11's admission Minimum Data Set (MDS) assessment dated 5/8/23, indicated R11 was cognitively intact, had clear speech, was understood and able to understand. R11 did not walk and required extensive assistance or was totally dependent on two staff for activities of daily living.<br><br>R11's care plan dated 5/3/23, indicated R11 was at risk for complications related to dialysis. An intervention included to send communication folder to dialysis with each run (dialysis session). The care plan lacked key elements of care for a resident receiving dialysis, including but not limited to the days of the week R11 attended dialysis, the mode of transportation to and from dialysis, ensuring R11 received breakfast prior to leaving for dialysis, the location of R11's dialysis access site (a port in his chest); that R11 had a fistula in his arm that wasn't being used and blood work and blood pressure could not be taken on that arm. The care plan lacked monitoring for risk factors and managing complications such as hemorrhage, access site infection, hypotension, and to whom to report concerns. The EMR (electronic medical record) had dialysis information in multiple locations: care plan, header on the opening page of the EMR and physician orders. This required nursing staff to | F 698 | those affected by the alleged deficient practice:<br><br>R11’s care plan will be updated to including monitoring for risk factors and managing complications and the facility will update other information surrounding dialysis including days of the week the resident will be receiving dialysis, mode of transportation to dialysis, ensuring that the resident receives breakfast prior to dialysis, location of dialysis site, that resident had a fistula in his arm that wasn't being used and that blood work and blood pressure could not be taken on that arm.<br><br>Pre-screening form, weight will be documented and sent to dialysis with the resident<br><br>Vital’s will be taken and documented after the resident returns from dialysis<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>The facility has identified 3 additional dialysis residents who will be audited to ensure that they are not affected by the same deficient practice<br><br>The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: | |

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| F 698 | Continued From page 39<br>know this and to look in multiple locations for information.<br><br>R11's physician orders related to dialysis included:<br>--5/2/23, Complete DaVita dialysis pre-screening form and fax to DaVita prior to dialysis appointment.<br>--5/6/23, Daily weight and sent results with to dialysis every day and night shift for dialysis.<br>--5/2/23, Upon return from dialysis, check full set of VS (vital signs).<br><br>During record review, the dialysis pre-screening form was documented on the TAR (treatment administration record) as having been sent to dialysis only four of 12 possible days in May and one of six possible days in June.<br><br>During record review, a weight had been documented on the TAR as having been obtained and sent to dialysis on only six of 12 possible days in May and three of six possible days in June.<br><br>During record review, vital signs (blood pressure, temperature, pulse, respiratory rate and oxygen saturation) had been documented as having been obtained post-dialysis only six of 12 possible days in May and four of six possible days in June.<br><br>During an interview on 6/12/23 at 5:56 p.m., R11 stated staff didn't check his dialysis access port in his chest, and only sometimes checked his vital signs upon return from dialysis. R11 stated he sometimes took an envelope from the facility to give to dialysis staff but did not bring one back.<br><br>During an interview on 6/14/23 at 10:00 a.m., | F 698 | The facility will ensure that all dialysis care plans are updated, that all information will be given to the dialysis company and that weights and vitals and will occur pre and post dialysis.<br><br>Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:<br><br>The DON or nurse designee will audit all care plans of residents with dialysis (4 current in the facility) to ensure that they are updated and contained all necessary information. The DON or designee will audit the TARs and sending of dialysis paperwork for each dialysis resident, each appointment for x2 weeks<br><br>Nursing staff will be educated on the facility dialysis process including; sending resident information to dialysis, taking weights before dialysis and vitals after dialysis<br><br>Completion date: 8/15/23 | |

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|---|---|---|---|---|
| F 698 | Continued From page 40<br>registered nurse (RN)-B stated not all nursing staff sent paperwork to dialysis with R11, adding not all nurses knew to do this. Further, RN-B stated night nurses were to have appointment paperwork set up and ready to go to dialysis with R11.<br><br>During an interview on 6/14/23 at 1:16 p.m., RN-C stated nursing staff were supposed to send paperwork to dialysis and it was the responsibility of the night shift nurse to prepare the paperwork. RN-C stated in the past, there had been a nursing order on the TAR to send paperwork to dialysis, but after the Covid-19 pandemic, it fell off the TAR when Covid-19 screening was no longer required to be faxed to dialysis.<br><br>During an interview on 6/15/23 at 7:29 a.m., RN-C stated that on dialysis days, which for R11 were Tuesdays, Thursdays and Saturdays, nursing staff should assess R11's vital signs when he returned from dialysis and review the post-dialysis paperwork. RN-C looked in R11's EMR and acknowledged vital signs had not consistently been obtained when R11 returned from dialysis. In addition, RN-C acknowledged weights had not been obtained according to the physician order.<br><br>During an interview on 6/15/23 at 7:58 a.m., the director of nursing (DON) and RN-A who was also the regional nurse consultant were informed of lack of weights and vital signs documented according to physician orders, lack of documentation being sent with R11 on dialysis days, and lack of key elements on R11's care plan pertaining to dialysis. RN-A stated it was the expectation that nursing followed physician orders and would expect R11's care plan to reflect | F 698 | | |

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| F 698 | Continued From page 41<br>standards of care for a resident receiving dialysis.<br><br>During a telephone interview on 6/15/23 at 9:07 a.m., RN-F stated dialysis wanted communication from the facility each day a resident came for dialysis. The information should include medications given that morning, an updated MAR, and face sheet. RN-F stated typically the facility would also send an appointment form which dialysis could write on at the end of R11's dialysis session to document pertinent information. RN-F stated the dialysis agency had not consistently received communication paperwork from the facility for R11.<br><br>The facility Hemodialysis policy dated 11/22/19, indicated residents who required dialysis would receive services consistent with professional standards of practice; staff would provide ongoing assessment of the residents condition and the resident would be monitored for complications before and after dialysis treatment. Facility staff and the dialysis center would have ongoing communication and collaboration regarding dialysis care and services. Ongoing assessment/evaluation of the residents condition and monitoring for complications would occur before and after dialysis treatment. | F 698 | | |

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|---|---|---|---|
| | 245517 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **06/14/2023** |

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

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/14/2023. At the time of this survey, OAKLAWN CARE & REHABILITATION CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/31/2023 |

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 |
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| K 000 | Continued From page 1<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>OAKLAWN CARE & REHABILITATION CENTER is a 1-story building with partial basement.<br><br>The facility was constructed at 2 different times. The original building was constructed in 1964 with construction determined to be of Type II ( 111 ) construction. An addition constructed in 1995 and was also determined to be of Type II ( 111 ) construction. | K 000 | | |

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| | 245517 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **06/14/2023** |

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| K 000 | Continued From page 2<br><br>Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.<br><br>The entire facility is fully fire sprinkler protected. 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.<br><br>The facility has a capacity of 70 beds and had a census of 45 at time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 353<br>SS=D | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____ | K 353 | | 7/31/23 |

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| | 245517 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **06/14/2023** |

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| K 353 | Continued From page 3<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.2.2. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 06/14/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that in the basement corridor there was a copper waterline supply line that had been attached and supported by the sprinkler system piping<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 353 | Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.<br><br>How corrective action will be taken for those affected by the alleged deficient practice:<br><br>Maintenance Director attached the refridgator supply line to the ceiling and removed the zip ties from the sprinkler system piping<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>Every resident has the potential to be affected by this deficiency<br><br>The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:<br><br>Maintance director will complete weekly audits and report any issues to the QAPI committee<br><br>Quality Assurance ,plans to monitor facility | |

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| | 245517 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **06/14/2023** |

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|---|---|---|---|---|
| K 353 | Continued From page 4 | K 353 | performance to make sure that corrections are achieved and are permanent:<br><br>Maintance director will complete weekly audits and report any issues to the QAPI committee<br><br>Completion date: 7/31/2023 | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of | K 918 | | 6/15/23 |

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| K 918 | Continued From page 5<br>maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 ( 2010 edition ), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2 These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 06/14/2023 between 9:30 AM and 1:30 PM, it was revealed during documentation review that no 36 month - 4 hour load bank documentation was presented for review.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 918 | Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.<br><br>How corrective action will be taken for those affected by the alleged deficient practice:<br><br>The facility had the 4 hour load bank tested on 6/15/2023<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents have the potential to be affected by the alleged deficiency.<br><br>The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:<br><br>Administrator will educate Maintenance director regarding completing appropriate | |

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| K 918 | Continued From page 6 | K 918 | testing.<br><br>Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent:<br><br>Maintenance director will review upcoming and overdue testing during QAPI.<br><br>Completion date: 6/15/2023 | |