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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OVK0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00038

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

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

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

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

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

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

6. DATE OF SURVEY **05/20/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 06/03/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 06/03/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2021

CMS Certification Number (CCN): 245517

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

Dear Administrator:

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

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

Effective May 14, 2021 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2021

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

RE: CCN: 245517
Cycle Start Date: February 18, 2021

Dear Administrator:

On April 30, 2021, we notified you a remedy was imposed. On May 20, 2021 the Minnesota Departments 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 May 14, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 15, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 10, 2021, 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 May 15, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 14, 2021, 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, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 3, 2021

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

Re: Reinspection Results
Event ID: OVK012

Dear Administrator:

On May 20, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 9, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OVK0

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Facility ID: 00038

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

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(L3) **OAKLAWN CARE & REHABILITATION CENTER**
(L4) **201 OAKLAWN AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

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

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6. DATE OF SURVEY **04/09/2021** (L34)

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2 AOA 3 Other

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FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 05/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 06/03/2021 (L20)

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

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____ 2. Facility is not Eligible
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02/01/1988
(L24)

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(L41)

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(L44)
B. Rescind Suspension Date:
(L45)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

April 30, 2021

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

RE: CCN: 245517
Cycle Start Date: February 18, 2021

Dear Administrator:

On March 10, 2021, we informed you that we may impose enforcement remedies.

On April 23, 2021, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 15, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 15, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 15, 2021.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 15, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Oaklawn Care & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 15, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by 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, MN 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 18, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 04/09/2021

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
E 000	Initial Comments On 4/5/21 - 4/9/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/5/21 - 4/9/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5517040C (MN00069120), H5517041C (MN00062982), H5517043C (MN00053863), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5517042C (MN00061126) and H5517044C (MN00057214). 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	C 04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		5/14/21

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 04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified atmosphere for 1 of 1 resident (R43) observed to have an uncovered catheter bag which was visible to others. Findings include: R43's Face Sheet, undated indicated R43 had a diagnosis of neuromuscular dysfunction of the bladder that can cause retention, Alzheimer disease and dementia. R43's annual Minimum Data Set (MDS) assessment dated 3/18/21, indicated R43 had severe cognitive disorder, does not speak, is rarely understood and requires extensive assist of two for transfers and bed mobility, is totally dependant on staff for locomotion and has an indwelling catheter. During observation and interview on 4/5/21, at 5:34 p.m., R43 was wheeled down a hallway in a wheelchair past the common room (television, computer and activities area), where four other residents were sitting, to the dining room without a cover on on the urine collection device (catheter	F 550	Affected resident (R43) was provided with a covered catheter bag. All residents were reviewed to ensure dignity related to the covering of catheter bags, if needed. All-staff education provided regarding resident rights related to dignity and ensuring a dignified atmosphere for all residents. Director of Nursing or designee will conduct random audits to ensure all resident catheter bags are covered. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	

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F 550	Continued From page 3	F 550		

bag). A family member (FM) indicated R43's catheter bag is never covered. He just notices the color of urine when he is here, but it doesn't bother him. FM further indicated if R43 still had her thought process, it would bother her.

During observation on 4/5/21, at 6:30 p.m., R43 was wheeled to the common area with the catheter bag uncovered under her chair and visible. Five other residents were present in the common room area.

During observation on 4/6/21 at 2:18 p.m., R43 was in the common area in her wheelchair with uncovered catheter bag under the chair and visible. Six other residents were present as bingo was being played at this time.

During observation on 4/7/21 at 7:09 a.m., R43 was in the common room with three other residents with uncovered catheter bag attached under the wheelchair and visible.

During interview on 4/7/21, at 2:02 p.m., nursing assistant (NA)-a indicated most catheter bags come with a cover but this one must not have, but generally they have the catheter bags covered.

During observation on 4/8/21, at 8:22 a.m., R43 was wheeled from the main dining area with multiple residents present, down the hallway to the common area with catheter bag under the wheelchair uncovered and visible.

During observation and interview on 4/8/21, at 10:38 a.m., NA-E wheeled R43 down hallway to R43's room and was assisted by NA-D using lift to assist R43 to her bed. NA-D indicated generally when residents are taken out of their

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F 550	Continued From page 4 rooms the catheter bag is covered. NA-D further added that some catheter bags come with a cover and others don't and apparently this one didn't. During interview on 4/08/21, at 11:36 a.m., the director of nursing confirmed catheter bags should be covered when residents leave their rooms or is visible. A policy and procedure related to ensuring catheter bags are covered was requested and not provided.	F 550		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		5/14/21

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F 657	Continued From page 5 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the plan of care related to denture use for 1 of 4 residents (R5) reviewed for activities of daily living (ADLs). Findings include: R5's annual Minimum Data Set (MDS) assessment dated 7/1/20, indicated no oral/dental issues. The MDS further indicated R5 had severe cognitive impairment. R5's care plan printed 4/8/21, indicated the resident had full upper dentures and on the bottom had some missing teeth with no problems noted. R5's care sheet utilized by the nursing assistants (NA) dated 4/7/21, indicated the resident had upper dentures and a lower partial. On 4/6/21, at 2:52 p.m. R5 was observed seated in a wheelchair in her room. R5 was interviewed at that time and confirmed being edentulous and opened her mouth to further confirm no teeth were present. Resident denied wearing dentures though stated she used to prior to having her remaining bottom teeth pulled. When interviewed on 4/7/21, at 2:18 p.m. nursing assistant (NA)-F stated being unaware if R5 had dentures. NA-F confirmed since starting her	F 657	Affected resident's (R5) care plan was revised to reflect the resident's current preferences related to denture use. All residents were reviewed for accurate documentation in the care plan related to oral cares and denture use and completed, if needed. All licensed staff were educated on the importance of timely care plan revision and updating resident preferences, as needed. Director of Nursing or designee will conduct random audits to ensure timely care plan revision related to resident preference for denture use. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	

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F 657	Continued From page 6 employment she had not witnessed the resident ever wearing dentures. When interviewed on 4/8/21, at 1:32 p.m. NA-E confirmed R5 used to wear dentures but had something done to her mouth making it sore so hadn't worn them for awhile. NA-E searched R5's medicine cabinet in the bathroom but was unable to locate the dentures. When interviewed on 4/8/21, at 1:40 p.m. nurse manager licensed practical nurse (LPN)-A stated being unaware if R5 had dentures or not and further stated the information on the care plan and NA care sheet may be old and need to be updated. LPN-A stated she would follow-up with LPN-B regarding R5's denture use. When interviewed on 4/9/21, at 8:43 a.m. LPN-A stated she had followed up with the NA's and LPN-B related to R5's denture use. LPN-A stated R5 used to have a lower partial but had seen the oral surgeon several months ago and had all existing bottom teeth removed. R5 did not want to be refitted with a lower denture and had been refusing to wear her top denture. LPN-A confirmed staff had found R5's denture in her room in her purse. When staff asked R5 if she wanted to wear it she refused and the denture was removed from her room. LPN-A confirmed R5's care plan was incorrect and would need to be updated. The policy titled, Care Planning, revised 6/2019, indicated the care plan is to be modified and updated as the condition and care needs of the resident changes.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		5/14/21

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F 658	Continued From page 7 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to administer prescription cream by trained or licensed staff for 2 of 6 residents (R34, R41) observed during medication administration. Findings include: R34's current physician orders included: Nystatin cream (a prescription medicine approved for the treatment of various fungal infections) 100,000 unit/GM (units per gram). Apply to skin creases topically two times a day for skin integrity. R34's care plan printed 4/7/21, indicated an alteration of skin integrity with risk of skin breakdown. Interventions included to monitor skin breakdown for signs/symptoms of infection and to document on skin conditions and keep MD (medical doctor) or PA-C (physician assistant-certified) informed of changes. On 4/7/21, at 10:50 a.m. licensed practical nurse (LPN)-A was observed setting up R34's medications to be administered via gastrostomy tube (g-tube). LPN-A stated she first had to sign off R34's creams that the nursing assistant (NA) had applied, in the electronic treatment administration record (eTAR). LPN-A stated they were just maintenance creams and that was why	F 658	Affected residents (R34 and R41) will have prescription creams administered by trained or licensed staff. All residents receiving prescription creams have the potential to be affected; all residents receiving prescription creams will have them administered by trained or licensed staff. All licensed staff were educated on proper administration of prescription creams by trained or licensed staff. Director of Nursing or designee will conduct random audits to ensure proper administration of prescription cream by trained or licensed staff. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	

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F 658	Continued From page 8	F 658		

the NA's were able to administer them.

When interviewed on 4/7/21, at 2:29 p.m. NA-I confirmed she had applied creams and powders to R34's extremities and groin that morning and obtained them from the trained medication aide (TMA). NA-I was unsure what the names of the creams and powders were.

On 4/8/21, at 8:54 a.m. TMA-A was observed delivering 4 different creams to R34's room in individual medication cups. On each cup was written the name of the cream; one cup was labeled Nystatin. NA-E and NA-F were in R34's room completing morning cares. TMA-A set the creams on the bedside table and instructed the NA's where the cream was to be applied on R34's body. TMA-A then asked the NA's if they would like her "cheat sheet" which indicated where each cream was to be applied and they indicated yes. TMA-A left the sheet on R34's bedside table then exited the room. NA-E was interviewed after TMA-A exited R34's room and confirmed when providing morning cares for R34, the NA's were expected to apply the creams brought to them by the TMA or the nurse.

R41's current physician orders printed 4/8/21, included: Treatment: Monitor erythematous (reddened skin) rash to scrotum and left inner thigh and diffuse erythematous rash extending left posterior thigh into buttocks. Wash affected area with mild soap and warm water, pat dry completely. Apply clotrimazole cream (an antifungal cream) every day and evening shift.

On 4/8/21 at 9:24 a.m. TMA-A was observed setting up a single dose of clotrimazole cream for R41. TMA-A was also going to apply a condom

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F 658	Continued From page 9 catheter for the resident. TMA-A entered R41's room with the needed cream and supplies; NA-F was already in R41's room providing morning cares. R41 was observed to have a reddened scrotum and inner thigh on the left side. TMA-A instructed NA-F to apply the clotriamazole cream to the rash on R41's left scrotum/inner thigh area so TMA-A wouldn't need to change her gloves prior to applying R41's condom catheter. TMA-A then applied the physician ordered cream for R41. When interviewed on 4/8/21, at 1:40 p.m. LPN-A confirmed NAs were allowed to administer creams for prevention of skin breakdown as they were given only a single dose in a medication cup and were directed exactly where to apply the cream. If the resident had an area they were monitoring then the nurse or TMA should be applying it. When asked if that would include a cream such as Nystatin or clotrimazole, LPN-A confirmed those were prescription creams and would need to check with the director of nursing (DON) to see what her expectations would be. When interviewed on 4/9/21, at 11:24 a.m. the DON confirmed NA's were not to be applying prescription creams for residents. A policy on medication administration was requested but not received.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to	F 676		5/14/21

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F 676	Continued From page 10 ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nail care was completed for 1 of 1 resident (R5) who required assistance with grooming, and were reviewed for activities of daily living.	F 676	Affected resident (R5) had nail cares completed. All residents were assessed for nail care and completion of nail trimming. NAR Hall sheets and resident care plans were	

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F 676	Continued From page 11 Finding include: R5's quarterly Minimum Data Set (MDS) assessment dated 12/29/20, indicated R5 had severely impaired cognition and required limited assistance with personal hygiene. R5's care plan printed 4/8/21, directed staff to check nail length and trim and clean on bath day and as necessary. Review of R5's Weekly Skin Inspections indicated the resident last had her nails trimmed on 3/9/21. On 4/5/21, at 4:10 p.m. R5 was observed seated in a wheelchair in her room. R5 had extremely long fingernails with some of them being jagged on the ends. R5 was unaware when her bath day was. R5 looked at her right thumbnail and stated, "This one needs to be trimmed". The thumbnail was jagged and had a v-shape out of part of the nail. On 4/6/21, at 2:52 p.m., 4/7/21, at 10:10 a.m. and 4/8/21, at 8:35 a.m. R5 was observed with long, jagged fingernails. When interviewed on 4/8/21, at 1:21 p.m. trained medication aide (TMA)-A stated residents routinely receive nail care on their bath day and as needed. TMA-A observed R5's fingernails and confirmed they were long and jagged. TMA-A further confirmed R5's bath day was on Tuesday evening (2 days prior) and nail care should have been completed at that time. When interviewed on 4/8/21, at 1:40 p.m. case manager/licensed practical nurse (LPN)-A	F 676	reviewed and updated, as needed. All-staff educated on ensuring all personal grooming needs were met, per resident plan of care. Director of Nursing or designee will conduct random audits to ensure completion of personal grooming. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations	

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F 676	Continued From page 12 confirmed nail care for residents should be completed on their bath day. Should the resident refuse their bath, they should still be reapproached for completion. The policy titled, Bath, Shower/Tub, revised February 2018, did not address providing nail care at the time of a bath or shower.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grooming, timely toileting and incontinence cares were provided for 3 of 3 (R34, R41, R43) residents reviewed for activities of daily living (ADLs), who were dependent upon staff for care. Findings include: R34's admission Minimum Data Set (MDS) assessment dated 3/26/21, identified R34 as having severely impaired cognition and required extensive staff assistance with personal cares, that included grooming and shaving. R34's current care plan dated 12/22/20, identified R34 as requiring assistance of staff with personal hygiene that included grooming. R34 required assistance due to self care deficit related to quadriplegia, osteoporosis and cognitive disorder	F 677	Affected residents (R34, R41, and R43) had personal cares completed. Care plans and hall sheets were reviewed and updated, as needed, to reflect resident needs. All residents that are dependent on staff for grooming, toileting, and repositioning have the potential to be affected. Care plans and hall sheets have been reviewed and updated, as needed. All-staff educated regarding grooming, timely toileting, and incontinence care for all residents. Director of Nursing or designee will conduct random audits to ensure completion of personal grooming, timely toileting, and incontinence care. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	5/14/21

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F 677	Continued From page 13	F 677		

Review of the nursing assistant (NA) care sheet dated 4/6/21, directed staff to assist R34 with all ADL's

During observation on 4/5/21, at 2:00 p.m. R34 was observed to have long facial hairs on the chin and upper lip.

During observation and interview on 4/6/21, at 2:30 p.m. R34 was observed again to have long facial hairs on the chin and upper lip. R34 confirmed he was not growing a beard or mustache and would like to be shaved.

During observation on 4/7/21, at 8:30 a.m.. R34 continued to have long facial hair on the chin and upper lip.

During interview on 4/7/21, at 9:00 a.m. nursing assistant NA-A and NA-B indicated R34 is shaved on bath days which is on Mondays and Thursdays. NA-A and NA-B confirmed R32's facial chin and upper lip hairs were long and should have been shaved. NA-A and NA-B further indicated R34 was unable to shave independently and required daily staff assistance.

During interview on 4/7/21, at 9:00 a.m. NA-C confirmed R34 required staff assistance with shaving and should be shaved daily if needed.

During interview on 4/8/21, at 10:00 a.m. licensed practical nurse (LPN)-A confirmed R34 requires daily assistance with ADL's. LPN-A further indicated the NA's should be checking R34 daily, and shaven when needed.

During observation on 4/8/21, at 2:00 p.m. R34 continued to have long facial hair on the chin and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 14 upper lip. R41 R41's diagnosis report printed on 4/9/21, indicated diagnoses of Alzheimer's disease, Parkinson's disease, diabetes, chronic kidney disease, and weakness. R41's quarterly Minimum Data Set (MDS) assessment dated 3/18/21, indicated R41 had moderate cognitive impairment, adequate vision and hearing, clear speech, understood others and was able to make himself understood. R41 was dependent upon staff for bed mobility, transfers, locomotion on the unit, dressing, toileting and hygiene. In addition, R41 had an external urinary catheter, and was frequently incontinent of bowel. R41's plan of care, last reviewed on 4/6/21, indicated R41 had frequent bowel incontinence and was to be checked every two hours and as needed. R41 also had an alteration in elimination,	F 677		

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was frequently incontinent of bladder and was to be toileted every two hours and as needed. R41 had an alteration in skin integrity and nursing staff were to keep his skin clean and dry, and his linen dry.

R41's order summary report printed on 4/9/21, indicated an order for a condom catheter; replace each morning and as needed.

During document review, a nine page, untitled task sheet dated 4/7/21, indicated R41 was to be toileted every two hours and prn, and was to wear a condom catheter in bed.

During document review, a physician note dated 3/4/21, indicated R41 had a nasty groin rash for several weeks and was using a condom catheter to attempt to keep the area dry, as he was incontinent of urine and stool. Skin: large pale pink area left medial thigh with slightly raised darker edges. Scrotum with irregular-shaped erythematous (red skin) rashes consistent with candida (yeast infection). Intertrigo (skin inflammation, usually in warm moist areas, such as the groin or between folds) groin.

During document review, a nurse practitioner (NP) note dated 3/8/21, indicated R41 had a rash and redness to left thigh and groin. In the middle of prior week, the NP had been notified by staff that R41's rash was not improving; the probable cause of rash continued to be his urinary and fecal incontinence. A condom catheter trial was recommended to help manage R41's urinary incontinence. The following day, staff reported the trail of catheter went well.

During an observation on 4/5/21, at 6:17 p.m.,

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while R41 was in the dining room, a strong smell of urine was noted on his side of the room. R41's bottom fitted sheet had a round damp circle on it measuring approximately 12 inches in diameter. The incontinence pad had a damp area on it also, approximately 12 inches in diameter.

Daily Care Sheets for the south wing where R41 resided indicated the date and times residents were checked, changed or toileted. The times were hand-written on the sheet by NA's. There was no corresponding name or initials to indicate who toileted residents.

On 4/6/21, the sheet indicated R41 was toileted at 2:00 p.m. However during a continuous observation from inside R41's room, or the hallway outside of R41's room from 1:29 p.m. to 3:48 p.m., no staff checked on him or toileted him. It wasn't until staff were asked to go into R41's room at 3:48 p.m. to check his brief, did he get toileted and changed. Observations and interviews on 4/6/21, include:
--1:29 p.m., R41 was laying in bed watching TV. Room had a strong, foul odor of stool.
--2:06 p.m., R41 was laying in bed with eyes closed. No one had come into R41's room, even though the foul odor was noticeable in the hallway outside of his room.
--2:37 p.m., R41 was laying in bed with his eyes closed.
--2:51 p.m., during an interview in the hallway outside of R41's room, nursing assistant (NA)-I stated she did not carry a NA task sheet. When asked how she knew the frequency at which a resident was to be repositioned or toileted, she stated she had that memorized.
--3:02 p.m., during an interview in the hallway outside R41's room, when asked how she knew

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which residents required repositioning or toileting at specific intervals, (NA)-L removed a sheet from her pocket which indicated R41 should be toileted every two hours and as needed.
--3:07 p.m., R41 was laying in bed with his eyes closed. No staff had come into his room since observation started at 1:29 p.m. despite foul odor permeating the hallway.
--3:16 p.m., trained medication aid (TMA)-A walked into R41's room to talk to his roommate. When asked if R41 participated in activities, TMA-A stated R41 didn't get out of bed except for meals.
--3:44 p.m., when asked, NA-L stated R41 was last toileted at 2:00 p.m. according to the Daily Care Sheet. However, this was not observed during continuous observation.
--3:48 p.m., NA-L was asked to check R41's brief. At R41's bedside, NA-L asked R41 if he needed to use the bathroom and he replied no. Strong, foul odor in room persisted. When NA-L checked R41's brief, it was saturated with urine and stool. When asked how it could be saturated with urine when R41 had a condom catheter, NA-L stated R41 tended to pull the catheter off. Noted R41's catheter was not in place when NA-L pulled back his brief. NA-L got R41 out of bed, into a wheelchair and into the bathroom. R41's fitted sheet had been soiled with urine and stool, his brief had been soiled with urine and stool, as were the cloth underwear with snaps that were over his brief, as were the rust colored sweat pants he was wearing. R41's coccyx was observed to have a reddened area about the size of a hand which appeared raised and bumpy. Redness was noted in his groin also. While R41 was sitting on the toilet, NA-L stripped the bed and replaced the sheets and incontinent pad. The bare rubber mattress was not cleaned prior to

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placing clean sheets on the bed. Licensed practical nurse (LPN)-A went into the bathroom to replace R41's condom catheter. LPN-A stated the condom catheter gets pulled off when R41 moves, adding that R41's urine was toxic to his skin and that was why he wore the condom catheter. After being cleaned up in the bathroom, a clean brief and sweat pants were put on, and R41 was assisted back into the wheelchair.

During an observation on 4/7/21, at 7:44 a.m., R41 was laying in bed with eyes closed; sheet partially covering him; wearing just a brief and the same sweatshirt from the day before. Room smelled of urine.

During an observation and interview on 4/7/21, at 9:20 a.m., (NA)-F and (NA)-G entered the room to get R41 up for breakfast. Observed R41's brief to be saturated with yellow urine when NA-F removed it. NA-F stated R41's condom catheter had fallen off. NA-F did not know when R41's brief had been checked or changed last. According to the Daily Care Sheet, his brief had been checked 8:30 a.m. and was dry (40 minutes prior to NA-F finding it saturated with urine). TMA-A came into R41's room and replaced his condom catheter. A new condom catheter was applied, which was attached to drainage tubing, which was attached to a urinary drainage bag. The drainage tubing was secured to R41's left leg with an elastic and Velcro strap. There was not enough give to the tubing -- if the strap slid down it could pull the condom catheter off. (NA)-G stated "we are constantly changing his condom catheter because it falls off." As NA-F continued to wash R41's groin, it was noted to be red. NA-F commented "it's pretty bad; I know it's sore." When R41 was turned, observed further redness

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on his coccyx and left posterior thigh. As R41 was assisted into a wheelchair for breakfast, observed bottom sheet, incontinence pad and disposable absorbent pad to be damp, which was verified by NA-F, but not changed. At 10:50 a.m., R41 returned from breakfast and was assisted into bed with the same soiled bedding still in place.

During an interview and observation on 4/7/21, at 1:30 p.m., R41 was returned to his room after lunch by NA-F who stated resident bed linen was changed once a week after their bath. As NA-F assisted R41 into bed, she noticed the soiled bedding and changed it. The bare rubber mattress was not cleaned prior to this. When asked if the condom catheter was still in place, NA-F stated it was, however when she removed his pants to his check brief, it came off. TMA-A came to the room to replace it. TMA stated when they first started using the catheter, his skin had improved, but it was worse again..."it's better than it was, but it's still not pretty."

During an interview and observation on 4/8/21, at 8:22 a.m., a very strong smell of urine was noted in the hallway outside R41's room and in his room. At 9:16 a.m., NA-F entered the room to get R41 up for breakfast. NA-F looked in R41's brief and stated the condom catheter was off again and his brief was saturated with urine. NA-F removed the brief and washed R41's perineal area. The condom catheter was replaced by TMA-A. Discussed leg strap with TMA-A and the short distance between catheter and strap which appeared to be the cause for the catheter frequently being pulled off. TMA-A stated they were looking into a different device to secure the tubing to prevent the condom catheter from being pulled off.

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During an interview on 4/8/21, at 9:58 a.m., licensed practical nurse (LPN)-B stated R41 was able to toilet himself; mostly for bowel movements, and added staff should be checking on him every two to three hours, checking either his brief or toileting him. LPN-B stated now that R41 had a condom catheter, it was easier to check R41. When asked when R41 was last toileted, she looked at the Daily Care Sheet for toileting and stated 5:15 a.m., adding she would have expected R41 to be looked at again between 7:00 a.m. and 8:00 a.m. LPN-B was informed he had not been looked at until 9:15 a.m. LPN-B stated NA's likely gave R41 a longer period of time since he had a condom catheter now, but should be looking for incontinent bowel movements sooner. Daily Care Sheets for toileting where reviewed with LPN-B for residents on the south unit were R41 resided. It was pointed out to LPN-B that on 4/6/21, 15 residents were checked, changed or toileted at 2:00 p.m. On 4/7/21, nine residents were checked, changed or toileted at 9:00 a.m., and seven residents at 11 a.m. With three or four NA's on the south unit, was it possible to check, change and toilet that many residents at the same time? LPN-B stated those times were likely not the exact times the activity occurred, as NA's don't document on the sheet right after the task was performed.

During an observation and interview on 4/9/21, at 8:44 a.m., R41 was laying in bed. At 9:47 a.m., he was still in bed. At 9:49 a.m., LPN-B was asked when the last time R41's brief had been checked or he was toileted and she replied she didn't know because it was not documented on the Daily Care Sheet. As R41's room was entered with LPN-B, without prompting, R41 stated "I'm being

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ignored." LPN-B asked him if he had been to breakfast yet, or if staff have been into his room yet and R41 replied no. When LPN-B pulled back R41's sheet, his brief, cloth underpants and sweat pants were visibly wet and R41's condom catheter was off again. At 10:04 a.m., (NA)-D came into the room and stated R41 had refused to have his brief checked and refused to get up when checked on earlier. LPN-B stated she expected staff to physically check a residents brief for someone like R41 who had Alzheimer's disease, not just ask if he needed to be changed, adding R41 was not always able to communicate his needs accurately.

During an interview on 4/9/21, at 11:01 a.m., the DON stated R41 was to be checked, changed or toileted every two hours and as needed. The DON stated R41 might refuse or deny he needed to be changed, but due to his cognitive level, she would expect staff to still check his brief. The DON was not aware R41 was not being checked, changed or toileted every two hours and stated it was her expectation staff followed R41's plan of care. The DON was not not aware of the frequency of R41's condom catheter coming off until recently, and stated they were looking into a more secure device to prevent this. When asked if staff routinely investigated strong odors of urine to determine the source, whether it was a saturated brief, soiled mattress or carpeting, the DON stated staff probably didn't notice the smells and admitted they could do a better job of this. The DON stated R41's mattress as well as another residents mattress had been replaced on 4/8/21, due to retaining the odor of urine.

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R43

R43's Face Sheet printed 4/8/21, included diagnoses of Alzheimer's, Epilepsy, dementia, anxiety, weakness and neuromuscular dysfunction of the bladder.

R43's annual Minimum Data Set (MDS) assessment dated 3/18/21, indicated R43 had severe cognitive impairment, does not speak, is rarely understood and rarely understands, requiring extensive assist of two for bed mobility, transfers, and personal hygiene.

R43's care plan dated 3/28/21, indicated R43 was totally dependent on staff for toilet use. An additional care plan dated 7/17/18, indicated an alteration in elimination related to Alzheimer's and included a toileting plan for checking and changing every two hours and as needed.

During observation and interview on 4/5/21, at 5:34 p.m., family member (FM) indicated he has asked them to allow R43 to rest in bed after meals and to wake R43 about an hour before meals and to check and change her as needed so she is awake before he comes to assist her to eat, but they don't do it and stated "I guess it is part of the way it just is."

R43 was continually observed on 4/7/21:
7:30 a.m., R43 brought out to the common sitting room from the dining room and placed in front of the television.
8:00 a.m., R43 dozing in chair without position change. No staff approached R43.
8:20 a.m., R43 remains in common sitting room,

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F 677	Continued From page 23 dozing in her chair. No staff have approached R43. 8:50 a.m., R43 remains sitting in common room in her wheelchair. No staff have approached R43. 9:15 a.m., R43 remains in common room dozing in her wheelchair. No staff have approached R43. 9:45 a.m., R43 remains in common room, no position changes and no staff have approached R43. 10:15 a.m., R43 remains in common room, no position changes and no staff have approached R43. 10:46 a.m., R43 remains sitting in the common room and no staff have approached R43. 10:52 a.m., R43 remains in common room, no position changes and no staff have approached R43. 11:15 a.m., R43 remains in common room, no position changes and no staff have approached R43. 11:54 a.m., R43 remains in common room, no position changes and no staff have approached R43. 12:10 p.m., R43 family member arrived and R43 moved to the dining room. Staff assisted resident to dining room, but did not toilet her. 12:55 p.m., R43 remains in dining room with family member. 1:10 p.m., R43 was moved back to the common room, remained seated in her wheelchair, was not toileted and placed in front of the television after family member left. 1:38 p.m., R43 remains in the common room, no repositioning or toileting completed. 1:59 p.m., the administrator approached and spoke to R43 and then requested staff lay her down for awhile as R43 appeared tired.	F 677		

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During interview on 4/7/21, at 1:22 p.m., a family member (FM) indicated he has requested R43 be put back in her bed in the morning for awhile so she isn't so tired when he comes to assist her to eat, but they don't listen to me. FM further indicated it is easier for them to leave her in her chair and sit her out in the area by the nurses station (common area) to keep an eye on her but is concerned they don't reposition or toilet her. FM indicated he has spoken to the facility many times about this issue and is very frustrated that it doesn't get done.

During observation and interview on 4/7/21, at 2:02 p.m., nursing assistant (NA)-A and NA-B, wheeled R43 to her room and using mechanical lift transferred R43 to her bed and checked incontinent pad. R43 had a large brown formed stool in incontinent pad with stool dried to the skin around the edges. NA-A was questioned when R43 was last toileted indicated she was unsure and would have to check. Skin was red after using wipes to clean dried stool off buttocks.

During interview on 4/7/21, at 2:19 p.m., NA-A indicated she was repositioned at 6:30 a.m., and 8:30 a.m., but not since then but should have been checked on and repositioned at 10:30 a.m. and 12:30 p.m.

During interview on 4/8/21, 8:28 a.m., NA-C indicated they try to lay down R43 in the mornings and check her pad, but it doesn't always happen if they are short staffed. NA-C indicated she is aware the family member has requested R43 lay down between meals.

During interview on 4/08/21, 11:36 a.m., the

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F 677	Continued From page 25 director of nursing (DON) confirmed she would expect staff to follow the plan of care and if it states every two hours, they should check and change the resident every two hours. The facility policy titled Activities of Daily Living (ADLs), Supporting, with revised date of 3/2018, indicated: 1. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent and in accordance with the plan of care, including support and assistance with elimination (toileting). 3. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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. This REQUIREMENT is not met as evidenced by:	F 684		5/14/21

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F 684	Continued From page 26 Based on observation, interview and document review, the facility failed to comprehensively assess and provide ongoing treatment for edema for 1 of 1 resident (R20), who required leg wraps and elevation to prevent and treat edema. Findings include: R20's Face Sheet printed 4/8/21, included diagnosis's of acute heart failure (heart muscle doesn't pump enough blood to meet body's demand), peripheral vascular disease (a circulation disorder that causes blood outside of heart and brain to narrow, block, or spasm), type 2 diabetes mellitus, chronic kidney disease stage 3 (moderate kidney damage), acquired absence of left leg below the knee and morbid obesity. R20s quarterly Minimum Data Set (MDS) assessment dated 2/5/21, included intact cognition with impairment of range of motion on one side of lower extremity with limb prosthesis. R20's provider orders dated 9/22/20, included compression to right leg in a.m.: Remove Rooke boot, moisturize leg with moisturizer in his room assessing for any alteration in skin integrity, notify provider if any skin problems occur. Apply knee immobilizer to right knee. Apply ACE wrap in figure 8, direction from toes to knees. Encourage resident to elevate legs as much as possible. A second order dated 12/29/20, included encourage resident to elevate legs every shift. R20's plan of care dated 10/15/20 included an alteration in skin integrity related to weakness and immobility post hospitalization related to left below the knee amputation. Intervention included compression to left extremity, encourage	F 684	Affected resident□s (R20) orders and treatments were reviewed and updated. R20's orders and care plan were reviewed and updated. R20 was assessed and treated for edema, per plan of care. All residents were reviewed for completion of assessment and treatment of edema, if needed. Care plans and hall sheets were reviewed for like-identified residents and updated, as needed. All-staff educated regarding timely assessment and treatment of edema. Director of Nursing or designee will conduct random audits to ensure timely assessment and treatment of edema for all residents, if required. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	

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elevation of lower extremities as much as tolerated. Care plan also included a self-care deficit related to weakness related to left below the knee amputation with intervention including assist of one with personal hygiene and dressing.

During observation and interview on 4/5/21, at 12:44 p.m., R20 was sitting in a recliner chair in his room with right leg dependant and foot on the floor, no ace wrap present and lower leg edema present. Skin was red from mid-calf to foot. Left leg was dependant also and a below the knee amputation present with no prosthesis on. R20 indicated he has a lot of swelling in his right foot and he is supposed to have his right leg wrapped in the morning when they remove his Rooke boot (vascular boot to naturally warm the limb) but it doesn't happen every day. R20 indicated he generally has to ask them to do it and then "half of the staff don't know how to do do I educate them on it when I have zero education in the medical field." R20 indicated the ace wrap really helps the swelling in his feet. R20 further stated the staff do not have time to remind him to keep his legs up as they are too busy for that.

During observation on 4/6/21, at 9:29 a.m., R20 was asleep in his chair with legs dependant and ace wrap present on right lower leg.

During interview on 4/6/21, at 2:26 p.m., R20 indicated he has not elevated his legs today. When asked if staff remind him he indicated no they don't have time for that.

During interview and observation on 4/7/21, at 7:11 a.m. R20 was in recliner chair with both legs dependant with right foot on the floor while nursing assistant (NA)-G present in the room.

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Rooke boot remained on R20's right leg and ace wrap was present on R20's bed. R20 requested NA-G put on his wrap and NA-G grabbed his prosthesis. R20 stated "not that" and asked her to come back in 10 minutes and wrap his leg. R20 stated some of these staff just don't know what they are doing.

During interview on 4/7/21, at 7:22 a.m., NA-G indicated R20 can get upset when you ask him to elevate his legs so I don't ask him to do it. NA-G indicated she hasn't wrapped his leg before and will get another aide to assist with him with that.

During interview and observation on 4/7/21, 9:31 a.m., NA-F indicated R20 gets upset when you ask him to elevate his legs, so I don't do it anymore. NA-F further stated he has a boot on in the mornings and then we wrap his leg when we take that off.

During interview on 4/8/21, at 10:50 a.m., licensed practical nurse (LPN)-B, who is also the care coordinator, indicated R20 should be elevating his legs and she would expect staff to prompt him to put his legs up throughout the shift.

During interview on 4/8/21, 11:33 a.m., the director of nursing (DON) indicated she would expect staff to remind R20 to raise his legs throughout the shift and to have his ace wrap put on in the mornings per orders. The DON did add she does she a lot of refusals documented for elevating his legs but was not aware staff are not reminding him.

A policy on edema prevention and treatment was requested but was not provided.

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F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 1 resident (R84) reviewed who had a stage 4 pressure ulcer with known risks for pressure ulcer development. The facility's failures resulted in R84 sustaining harm when the resident developed an unstageable pressure ulcer to the left heel. Findings include: Pressure ulcer stages, identified from the National Pressure Ulcer Advisory Panel (NPUAP): Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage	F 686	Affected resident (R84) was seen by Mankato Clinic wound nurse practitioner on 04/12/21, new orders placed for daily inspection of wounds, repositioning at least every two hours when in bed/chair to prevent pressure to bony prominences, and to limit chair sitting to two hours. Resident R84 continues to have Weekly Pressure Wound Evaluations completed and continues to be seen by Mankato Clinic wound nurse practitioner bi-weekly. All residents were assessed who currently have identified pressure wounds for appropriate interventions and care plans and physicians updated, as needed. All licensed nursing staff were educated on how to ensure proper assessment, monitoring, and implementation of pressure reliving interventions for residents with identified pressure	4/12/21

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F 686	Continued From page 30 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuate) on the heel or scenic limb should not be softened or removed. R84 was admitted to the facility on 8/4/20, with diagnoses identified on the diagnosis report sheet including: diabetes mellitus, stage 4 pressure ulcer on the sacrum, kidney failure and protein calorie malnutrition. During observation and interview on 4/5/21, at 5:00 p.m. R84 was sitting in his wheelchair eating. R84 was noted to have a redistribution boot on the left foot and a sock on the right foot. R84's right heel was pressing against the foot pedal of the wheelchair. R84 stated he had a sore on his left heel, but was unsure about the right heel. R84 confirmed staff had been putting a protective device on only the left heel. R84 stated he had frequent pain in both heels. R84 further indicated he had an open sore on his coccyx area. Review of the Admission Data Collection sheet dated 8/4/20, identified R84 as requiring extensive assistance with mobility, having clear speech, able to understand and able to be understood, with good memory recall. The admission skin assessment was left "blank" therefore not identifying R84's current skin condition. Review of a weekly wound evaluation dated 8/7/20, identified R84 as having a stage 4 pressure ulcer on the coccyx. The ulcer was identified as measuring 2.5 centimeters (cm) in length, 1.0 cm in width, and 2.5 cm in depth. The ulcer was further described as having full	F 686	concerns. Licensed nursing staff were also educated on the new process for communicating skin concerns identified on admission skin assessment, as well as any new skin concerns noted on weekly skin assessments to the on-call nurse manager and Director of Nursing. Director of Nursing or designee will conduct random audits to ensure proper assessment, monitoring, and implementation of pressure relieving interventions for residents with skin integrity issues. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	

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thickness tissue loss with adipose exposure, margins severely macerated (skin is soft and moist around the edges of a wound), wound edges slightly rolled, heavy yellowish drainage present, undermining (when tissue under the wound edges becomes eroded) and as having a foul odor. Interventions implemented included: pressure redistribution cushion on wheelchair, pressure relieving mattress and a repositioning schedule. In addition, the assessment indicated R84 was admitted with a significant pressure wound on 8/4/20, which was first assessed by facility staff 8/6/20.

Review of a skin assessment dated 8/24/20, identified R84's left and right heels were "boggy". No other description of the heels was documented. In addition, no additional interventions were implemented to prevent breakdown of the heels.

Review of a weekly wound evaluation dated 9/2/20, identified R84's left and right heels were "boggy". No other description of the heels was documented. Also, no additional interventions were implemented to prevent breakdown of the heels.

Review of a weekly wound evaluation dated 9/14/20, did not address R84's heels which had been identified to be "boggy" 8/24/20 and 9/2/20. There were no additional interventions identified to prevent breakdown of the heels.

Review of a weekly wound evaluation dated 9/25/20, identified a suspected deep tissue injury to the left heel. Measurements were 3.4 cm in length, 5.5 cm in width and 0.0 cm in depth. The area was described as being purplish red in color

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and skin being soft and "boggy". Interventions implemented included: pressure redistribution boots on at all times and air mattress on bed. Although R84 was first identified as having "boggy" heels 8/24/20, no new interventions were implemented until this evaluation 9/25/20.

Review of a weekly wound evaluation dated 10/12/20, identified R84's left heel as blistering and worsening. The evaluation indicated R84's heels and feet were pressing against the footboard of the bed. The pressure ulcer to the left heel was described as having partial tissue loss, discolored skin and scant serosanguinous drainage. Measurements were identified as 5.0 cm length by 4.5 cm width and 0.0 cm depth, and the wound was identified as unstageable.

Review of R84's admission Minimum Data Set (MDS) assessment dated 8/7/20, identified R84 as having a baseline interview for mental status (BIMS) score of "15" (no cognitive impairment). The MDS identified R84 as requiring extensive assistance with bed mobility and positioning, indicated R84 as at risk for pressure ulcers, and indicated R84 had a current stage 4 pressure ulcer. Interventions included: pressure reducing mattress, chair cushion, turn and repositioning program and pressure ulcer care.

Review of R84's quarterly MDS assessment dated 2/2/21, identified R84 as having a BIMs score of "15." The MDS identified R84 as requiring extensive assistance with bed mobility and positioning, indicated R84 as at risk for pressure ulcers, and indicated R84 had a current stage 4 pressure ulcer, and an unstageable pressure ulcer. (The unstageable pressure ulcer was not present on admission) (right heel).

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Interventions included: air mattress, chair cushion, turn and repositioning program and treatment dressing.

Review of the admission Braden scale dated 8/7/20, identified R84 as having mild to moderate risk for pressure ulcers. The assessment identified R84 as having a stage 4 pressure ulcer on the sacrum. In addition, R84 was identified to require extensive assistance with ADL's (activities of daily living) that included lifting legs in and out of bed. Interventions identified included: turning and repositioning program, redistribution cushion in chair, air mattress, weekly wound assessments and a protein supplement twice daily.

Review of the R84's admission care plan dated 8/26/20, identified R84 as being at risk for skin breakdown related to acute kidney failure, limited mobility and current pressure ulcers. Interventions were identified as including: monitor skin integrity weekly, turn and reposition every 2 hrs (hours) and as needed (PRN), pressure redistribution cushion to chair, air bed, weekly wound measurement to sacrum and follow wound care.

Review of the current plan of care dated 2/12/21, identified R84 as having alteration in skin integrity related to pressure ulcers on the coccyx and left heel. Interventions included: offload left heel with a donut cushion at all times, weekly wound assessments, monitor skin daily, turn and reposition every 2 hours, pressure reduction cushion to chair, air mattress and encourage R84 to accept cares, due to occasional refusals.

Review of the nursing assistant (NA) resident care sheet dated 4/2/21, indicated R84 requires

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assistance with ADLs, reposition every 2 hours/ remind the resident to reposition, may be up in chair no more than 2 hours at a time and blue heel donut to the left heel at all times. There were no preventative measures identified for the right heel.

Review of the current physicians orders dated 4/8/21, included skin /pressure ulcer orders. These orders included: ensure heels are floated and pressure relief boots are in place. ensure feet are not rested on the foot board, weekly skin audits, wound care every 3 days and as needed to coccyx and wound care to left heel daily and off load at all times.

During observation and interview on 4/6/21 at 4:00 p.m., R84 was observed to be sitting outside the facility with a staff person. R84 was in the wheelchair with both feet resting on the foot pedals. R84 was observed to have thick socks on both feet but did not have a redistribution device on either feet. R84 stated he was not sure if they were needed when he was up in his chair.

During observation and interview on 4/8/21 at 11:00 a.m., R84's left heel pressure ulcer was measured by licensed practical nurse (LPN)-A. The left heel ulcer measured 5.6 cm by 5.0 cm by 0.0 cm. The area was identified by LPN-A to be covered with 80% eschar, 10% slough and 10% granulation. There was an increase in depth from the previous week, but the width and length had improved. During this time, R84 was resting in bed and noted to have a blue heel doughnut under the left heel, but did not have any kind of redistribution device under the right heel. The right heel was resting on the bed. The surveyor asked LPN-A to check the resident's right heel

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that was covered with a sock. LPN-A described the right heel as soft, slightly pink in color, with hardened skin around the edges. The center area measured a 1/4 inch of discoloration and blanchable. There were no visible open areas. R84 stated he was having pain in both feet. Interview with LPN-A at this time, confirmed R84 did not have any orders for a pressure redistribution device to R84's right heel and that there had been no previous redness in the area. LPN-A stated the wound nurse is currently responsible to monitor R84's skin.

During interview on 4/7/21, at 9:30 a.m. NA-A and NA-B indicated R84 will reposition self most of the time, but staff need to remind him occasionally. NA-A and NA-B confirmed R84 was to have a blue heel donut to his left heel at all times when in bed. NA-A and NA-B also verified R84 did not have any kind of pressure reduction device for the right heel. NA-A and NA-B stated R84 utilizes the blue heel donut when in bed, but verified staff are not always able to place the donut properly when R84 is up in the wheelchair.

During interview with RN-A on 4/8/21, at 1:00 p.m. RN-A confirmed R84 did not have orders for a pressure redistribution device to the right heel, even though R84 was at risk for pressure ulcers. RN-A confirmed R84's admission skin assessment identified "boggy" heels with no interventions implemented, to prevent skin breakdown. RN-A verified after R84 was identified with "boggy" heels, R84 developed an unstageable pressure ulcer to the left heel 6 weeks later.

The Director of Nursing (DON) and administrator were interviewed at 1:30 p.m. on 4/8/21. The

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F 686	Continued From page 36 DON confirmed R84 was admitted without a skin assessment completed until 3 days later. The DON also verified R84 was at risk for skin breakdown. The DON stated when R84's heels were identified to be "boggy" interventions should have been implemented. The DON further stated she would expect staff to assess the resident's skin on admission in order to determine interventions needed to prevent skin breakdown. The facility's 7/18 policy Skin Assessment and Wound Management, included: Initiate a weekly pressure wound evaluation when a pressure ulcer is identified, notify the wound nurse and update provider. Provide information regarding clinical identification of pressure ulcers/injuries and associated risk factors.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		5/14/21

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F 688	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to restore, maintain and prevent loss of range of motion (ROM) for 3 of 3 residents (R8, R2 and R21), reviewed for range of motion (ROM) and mobility. Findings include: R8 was admitted to the facility on 2/16, with diagnosis (identified on the diagnosis report sheet in the medical record) dated 4/9/21, that included: cerebral vascular accident (CVA) (stroke) polyneuropathy (malfunction of peripheral nerves throughout the body) chronic kidney disease, osteoarthritis (arthritis in the joints) and fracture of the right femur. Interview and observation on 4/7/21, at 9:00 a.m. R8 was observed sitting in a wheelchair in the lounge watching TV. R8's left hand was noted to be clenched and resting on his lap. When asked if he could open his right hand he was only able to open it partially. R8's 2nd, 3rd and 4th fingers noted to be slightly bent and the pinky finger was almost completely closed. R8 did not have a splint or any adaptive device to prevent contractures. R8 complained of discomfort when attempting to open his hand. Observation on 4/8/21, at 12:00 p.m. R8 was observed eating dinner. R8 continued to have his left hand clenched tightly and resting in his lap. R8 was eating and moving items on his tray with his right hand and did not move his left hand or arm throughout the entire meal.	F 688	Affected residents (R8, R2, and R21) were reviewed for ROM, plan of care and interventions have been reviewed and updated to reflect ROM. ROM for all affected residents was completed. All current residents who have been identified for ROM, interventions and plan of care have been reviewed and updated. All-staff were educated on the important of ROM programs and ensuring residents are receiving appropriate treatment to increase range of motion and/or to prevent further decease in range of motion. Education will continue to be provided to staff, as needed. Director of Nursing or designee will conduct random audits to ensure completion of ROM services provided by the facility. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	

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R8's quarterly Minimum Data Set (MDS) assessment dated 1/4/21, indicated R8 required extensive assistance with activities of daily living (ADL's). The MDS further indicated R8 did not have any impairment in ROM in the upper extremities. The MDS indicated R8 had severe cognitive impairment..

R8's care plan dated 1/13/21, identified R8 as having a self care deficit related to dementia and mobility deficits related to a CVA. R8 requires assistance with ADL's that included extensive assistance with upper extremity dressing. The care plan did not include R8's limited ROM in the left hand and fingers.

Review of R8's medical record did not include occupational therapy documentation or that R8 had ever received services for the left hand

R8's current physicians orders dated 4/9/21, did not include any orders for therapy services, ROM or adaptive devices to prevent contractures in R8's left hand.

Interview on 4/7/21, at 9;30 a.m. nursing assistant (NA)- B indicated R8 has kept his left hand and fingers closed for several months. NA-B stated R8 will complain of pain at times in his left hand when assisting him with dressing. NA-B further indicated there was no current treatment implemented for R8's left hand to prevent contractures or further impairment in ROM.

During interview on 4/7/21, at 10:00 a.m. registered nurse (RN)-A confirmed R8 was unable to open his hand fully without staff assistance. RN-A also confirmed R8's fingers

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were difficult to open and the pinky finger could only be opened partially with assistance. RN-A stated R8 did not receive therapy services, ROM or adaptive devices to prevent contractures or worsening of limited ROM.

Interview on 4/7/21, at 10:30 a.m. trained medication assistant (TMA)-A indicated R8 has had limited ROM is his left hand and fingers for several months. TMA-A confirmed R8 did not receive treatment to prevent contractures/further limited ROM in the left hand. TMA-A further indicated R8 always favors his left hand and has it closed resting on his lap.

R2

R2's diagnosis report dated 4/9/21, indicated a diagnosis of hemiplegia (paralysis of one side of the body) following a stroke. R2 had paralysis on the left side of his body.

R2's annual Minimum Data Set (MDS) assessment dated 3/24/21, indicated R2 was cognitively intact, had adequate hearing and vision, clear speech, understood others and was able to make himself understood. R2 was dependent upon staff for bed mobility, transfers, dressing, toileting and hygiene. In addition, R2's care area assessment related to rehabilitation potential indicated staff would follow therapy recommendations for activity of daily living (ADL) function. R2 was able to self-propel his wheelchair in his room and hallways using his right arm.

R2's orders reviewed in the electronic medical

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record (EMR) on 4/5/21, and dated 12/7/19, indicated R2 was to receive passive range of motion (PROM) to his left arm, and also upper body exercises with a weight in his right hand. The order indicated this was to occur every evening. R2's treatment administration record (TAR) reflected the same order. For the months of February, March and April 2021, the TAR indicated R2 received PROM every evening with the exception of three dates in February. R2's orders also indicated staff were to document refusals of care/treatments each shift.

R2's plan of care, last reviewed on 1/6/21, indicated R2 would show improvement to the maximum potential for ADL's and would be free from signs and symptoms related to stroke, including contractures (tightening of muscles, tendons, ligaments or skin). The care plan did not address R2's left arm contracture, nor did it mention the PROM ordered on 12/7/19.

During an observation and interview on 4/5/21, at 2:40 p.m., R2's left wrist and elbow were observed. R2's left arm was flexed at the elbow and his right wrist was flexed at the wrist. R2 was not able to extend either his elbow or wrist. R2 stated he had the contractures for awhile, but not as tight as they were now.

During an interview on 4/7/21, at 7:09 a.m. licensed practical nurse (LPN)-A stated they didn't really use a restorative binder (a resource where resident-specific PROM exercise sheets were kept for staff reference). LPN-A stated occupational therapy (OT) staff wrote orders for PROM and nursing assistants (NA's) performed it. When asked how a NA would know which PROM exercises to do with a resident if they

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didn't have a reference, LPN-A stated NA's had training on PROM.

During an interview on 4/7/21, 7:15 a.m., when informed he had an order for PROM to occur in the evening, R2 stated "it may well be, but it's not being done." R2 stated he did not use weights to strengthen his right arm either.

During document review, a nine page, untitled NA task sheet dated 4/7/21, indicated R2 was to receive PROM to his left arm, 10 times daily and upper body exercise with weight in right hand, daily. At the top of the form in bold, capital letters was "AMBULATION & ROM MUST BE DONE!!"

During record review, a clinic visit dated 3/26/21, indicated R2 had hemiplegia from a stroke affecting his left side. Physical and occupational therapy were to evaluate, with the goal of increasing his strength so R2 could assist with ADL's.

During an interview on 4/7/21, at 8:06 a.m., occupational therapist (OT)-B stated R2 previously had OT services but when progress wasn't being made, he was put on a PROM plan for both upper extremities. OT-B stated OT wrote the order and NA's performed the PROM. OT-B went to R2's room to look for his PROM plan, (pictures of exercises individualized for R2). R2 stated he did not recall receiving a PROM exercise guide and was not able to locate it in his room. OT-B then returned to the nurses station and from a cupboard, retrieved a binder titled: East Wing Restorative Nursing Communication Book. OT-B stated OT placed all PROM plans for residents on the east wing (where R2 resided) in this binder. OT-B located R2's PROM exercises,

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dated 9/14/19, which indicated exercises to be done to left shoulder, arm, elbow, forearm, wrist and hand. In addition, exercises for the right hand included the use of a three pound weight. OT-B verified it was R2's most current plan.

During an interview on 4/8/21, at 9:58 a.m., (LPN)-B stated NA's were supposed to do PROM on R2 in the evening. When asked how she accounted for R2 stating it wasn't being done when the TAR reflected it was, LPN-B stated nursing probably did not check with the NA, assumed the NA did it and just signed off on it. LPN-B added that R2 would not likely refuse PROM if offered.

During an interview on 4/9/21, at 7:56 a.m. with (NA)-J and (NA)-I, both were aware R2 was to receive PROM, but neither worked the evening shift and stated they didn't know if R2 received or refused PROM.

During an interview on 4/9/21, at 8:06 a.m., when asked how NA's know when a resident has PROM, (NA)-K stated therapy usually did the PROM, but sometimes NA's did it. NA-K removed a multiple page, untitled document from her pocket stating "we look at this and it will tell us." When asked if NA's provided PROM for R2, she looked at the sheet and pointed to R2's page which indicated PROM to left arm 10 times daily. NA-K stated R2's PROM was done in the evening and since she didn't work the evening shift, had not done it.

During an interview on 4/9/21, at 10:15 a.m., the director of nursing (DON) verified R2 was to receive PROM to his left arm, and upper body with a weight in his right hand. The DON stated

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nurses oversaw NA's to ensure PROM was being done. The DON reviewed R2's TAR and stated PROM was documented by a nurse as being done every day. The DON stated when a NA completed PROM, he/she informed the nurse and the nurse documented it on the TAR. The DON noted there were no PROM refusals documented in R2's record. When informed R2 stated PROM was not being done, the DON was unaware of this and admitted it was likely not being done, given R2 was cognitively intact and would know if it was not being done. The DON stated likely the nurse asked the NA if it had been done, but did not verify it had been done.

R21

R21's diagnosis report dated 4/9/21, indicated a diagnosis of hemiplegia (paralysis of one side of the body) following a stroke. R21 had paralysis on the left side of his body.

R21's quarterly Minimum Data Set (MDS) assessment dated 2/5/21, indicated R21 was cognitively intact, had adequate hearing and vision, unclear speech, understood others and was able to make himself understood. R21 was dependent upon staff for bed mobility, transfers, dressing, toileting and hygiene. R21 was able to self-propel his wheelchair in his room and hallways using his right arm.

R21's physician orders initiated at the time of admission, included standing orders which indicated physical therapy (PT) and occupational therapy (OT) to evaluate and treat. R21's orders also indicated staff were to document refusals of care/treatments each shift.

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R21's plan of care, last reviewed on 2/16/21, indicated R21 was to have gentle range of motion (ROM) daily, and the instructions for this were in the restorative book. In addition, R21 would remain free of complications or discomfort related to hemiplegia, would show improvement to maximum potential with mobility, and would improve current level of function as evidenced by needing less assistance with ADL's.

R21's treatment administration record (TAR), indicated R21 was to receive passive range of motion (PROM) in the morning and the instructions for this were in the restorative binder. According to the TAR, PROM exercises were done daily in February, March and April, 2021. No refusals were noted.

During an interview and observation on 4/5/21, at 2:12 p.m., R21 stated he did not receive PROM or therapy services, but he had in the past. R21's left arm was observed resting on a flat arm support attached to his wheelchair. R21 stated he had not been able to move his left arm since his stroke and had a lot of pain in that arm. R21's right hand was observed resting in a slightly clenched position.

During an interview on 4/7/21, at 7:09 a.m. licensed practical nurse (LPN)-A stated they didn't really use a restorative binder (a resource where resident-specific PROM exercise sheets were kept for staff reference). LPN-A stated occupational therapy (OT) staff wrote orders for PROM and nursing assistants (NA's) performed it. When asked how a NA would know which PROM exercises to do with a resident if they didn't have a reference, LPN-A stated NA's had training on PROM.

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During an interview on 4/7/21, at 8:06 a.m., occupational therapist (OT)-B retrieved a binder from the nurses station titled: East Wing Restorative Nursing Communication Book. OT-B stated OT placed all PROM plans for residents on the east wing (where R21 resided) in this binder. OT-B located R21's PROM plan (exercises), dated 7/29/19, which indicated exercises to be done to both upper extremities to include elbows, wrists and hands. OT-B verified it was R21's most current plan.

During an interview on 4/7/21, at 1:54 p.m., (NA)-L stated R21 received PROM to his left arm in the evening, but sometimes he refused due to severe pain. When this occurred, NA-L informed the nurse.

During an interview on 4/8/21, at 9:58 a.m., (LPN)-B stated R21 should be receiving PROM, however the activity director who used to do it stopped due to Covid-19 concerns, and LPN-B didn't know if it had been resumed.

During an interview on 4/8/21, at 11:25 a.m. R21 and family member (FM)-C were in the activity room playing cribbage. FM-C expressed concern that R21's right hand was becoming contracted. FM-C took R21's hand and stated "look how his fingers are becoming clenched." Then FM-C manually opened R21's fingers. FM-C indicated awareness that R21 was not receiving PROM anymore and was not happy about it; expressing concern that R21's contractures and pain would worsen.

During an interview on 4/9/21, at 7:34 a.m., (NA)-A and (NA)-J were in R21's room to get him

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out of bed and dressed. NA-A stated R21 received PROM as it was listed on his care plan. NA-J stated therapy usually did the PROM, but sometimes nurses or NA's did it. NA-J stated they did R21's PROM when they got him out of bed... "we pull his arm back to stretch it out."

During an interview on 4/9/21, at 8:06 a.m., when asked how NA's know when a resident has PROM, (NA)-K stated therapy usually did the PROM, but sometimes NA's did it. NA-K removed a multiple page, untitled document from her pocket stating "we look at this and it will tell us." When asked if NA's provided PROM for R21, she looked at the sheet and pointed to R21's page which indicated: daily ROM to arms in AM. See Restorative communication book for OT recommendations. NA-K stated she had not taken care of R21 in a while, so had not done his ROM.

During an interview on 4/9/21, at 10:28 a.m., the director of nursing (DON) stated activities staff did R21's PROM. The DON was informed that according to LPN-B, activities staff stopped doing it some time ago due to Covid-19 concerns. The DON looked on the NA task bar (a list of NA tasks identified in the EMR) and it indicated R21 should have PROM to his left arm on Monday, Wednesday and Friday. The DON was informed that OT's recommendations indicated R21 should have PROM to both arms, one to two times per day, and that R21 and his wife stated no PROM exercises were occurring. The DON was informed FM-C was concerned this will result in more contractures and pain for R21. The DON admitted it was likely not being done, given the comments by R21 and FM-C. The DON assumed activities staff had been doing PROM. When

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asked how she accounted for R21 and FM-C stating PROM wasn't being done when the TAR reflected it was, the DON stated the nurse likely asked the NA if it had been done, but did not verify it had been done. The DON noted there were no PROM refusals documented in R21's record.

During an interview on 4/9/21, at 12:37 p.m., the DON indicated she received R21's PROM exercise sheets from physical therapy assistant (PTA)-D which indicated R21 was to have PROM to both right and left arms one to two times per day. The DON admitted there were discrepancies between R21's plan of care, OT's recommended PROM exercises, the paper NA task sheet, and the NA task list in the EMR, and immediately sent an email to OT requesting them to evaluate and treat R21 for PROM. In addition, the DON added PROM to both extremities to the NA task list in the EMR to ensure it would get done.

The facility policy titled Restorative Nursing Services, with revised date of July 2017, indicated the following:
1. Residents would receive restorative nursing care as needed to help promote optimal safety and independence.
2. Restorative nursing care consisted of nursing interventions that may or may not be accompanied by formalized rehabilitation services, such as OT.
3. Restorative goals and objectives were individualized and resident-centered, and were outlined in the residents plan of care.
4. The resident would be included in determining goals and the plan of care.
5. Restorative goals included maintaining dignity, independence, self-esteem and

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F 688	Continued From page 48 maintaining strength. The facility policy titled Resident Mobility and Range of Motion, with revised date of July 2017, indicated: 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited ROM will receive treatment and services to increase and/or prevent a further reduction in ROM. 3. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. 4. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives. 5. Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the residents condition or needs.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was	F 693		5/14/21

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F 693	Continued From page 49 clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure placement of gastronomy tube (G-tube) tube inserted through the abdomen delivering nutrition and medication directly into the stomach) before giving medications to 1 of 1 resident (R34) observed with a G-tube. Findings include: R34's quarterly Minimum Data Set (MDS) assessment dated 3/10/21, indicated R34 had severe cognitive impairment with diagnoses including traumatic brain injury. The MDS further indicated R34 was totally dependent on staff for all activities of daily living. R34's care plan printed 4/7/21, indicated a potential for alteration in nutrition related to need for tube feeding for total nutrition secondary to diagnoses of quadriplegia, epilepsy, and dysphasia. Interventions included to check placement of G-tube prior to meds and feedings with stethoscope. R34's current physician orders printed 4/7/21, indicated: Check for G-tube placement prior to	F 693	Affected resident (R34) had G-tube orders reviewed and clarified and continues with current physician order for placement, per physician orders. All like-residents were assessed and had placement of G-tube checked, per physician orders, as needed. Care plans and hall sheets have been reviewed and updated, as needed. Education was provided to licensed nursing staff to ensure proper placement of G-tube prior to administration of nutrition and/or medication. Director of Nursing or designee will conduct random audits to ensure staff are checking for proper placement of G-tube prior to administration of nutrition and/or medication. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	

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F 693	Continued From page 50 meds and feedings with stethoscope. Two times a day AND four times a day. On 4/7/21, at 10:50 a.m. licensed practical nurse (LPN)-A was observed setting up medications and nutritional feeding via G-tube for R34. Prior to administering the medications and feeding, LPN-A attached a 60 cubic centimeter (cc) syringe to the end of R34's G-tube and pulled back to check for residual. LPN-A then proceeded to administer R34's medications followed by his feeding. When interviewed following administration, LPN-A confirmed ensuring placement of R34's G-tube by checking the residual. LPN-A stated if the residual was greater than 150 cc's the feeding would be held. When interviewed on 4/9/21, at 11:24 a.m. the director of nursing (DON) confirmed checking placement of a resident's G-tube should be performed through auscultation (listening to sounds arising within organ) with a stethoscope and also checking for residual through the tube. The policy titled Enteral Tube Medication Administration, dated April 2018, indicated: With gloves on, check for proper tube placement using air and auscultation only. Never check placement with water.	F 693		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		5/14/21

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 04/09/2021

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F 755	Continued From page 51 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for periodic reconciliation of controlled or narcotic medications in 1 of 1 emergency kit (E-Kit) to prevent potential loss or diversion. This had the potential to affect any of the 52 residents present in the facility who may require controlled medications from the E-Kit. Findings include: On 4/9/21, at 9:20 a.m., a tour of the North unit	F 755	Affected E-Kit reviewed and reconciled. Pharmacy reached out to applicable vendor and verified that all tags must have an identification number when being received by the facility. All residents have the potential to be affected. All licensed nursing staff educated on proper reconciliation, storage, and verification of E-Kit identification tag. Nurses advised pharmacy has reached out to the vendor to ensure that all	

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F 755	Continued From page 52 medication room was conducted with licensed practical nurse (LPN)-B. Located within the medication room was a refrigerator with an E-Kit with a green unnumbered tag present that included lorazepam (an anti-anxiety medication/controlled substance). LPN-B indicated if the E-Kit is opened and something taken out, they put a red numbered tag back on kit until the pharmacy comes to change out the E-Kit. LPN-B was unsure how often pharmacy comes to the facility. LPN-B further indicated she is aware lorazepam is in the E-Kit but indicated they do not count it daily with the narcotic counts. On 4/9/21 at 10:08 a.m., review of the narcotic log book on the North unit, did not include lorazepam from the E-Kit. During interview on 4/9/21, at 9:36 a.m., the director of nursing indicated the E-Kit gets replaced every Monday, and confirmed the lorazepam is not getting counted every day. The policy titled, Controlled Medication Storage, dated 4/14, included: If a scheduled III, IV, and V medication is not supplied in a unit dose automatic exchange system, the facility must implement an accountability record system. At each shift change, a physical inventory of all controlled medications is conducted by 2 authorized medication passers.	F 755	incoming e-kits are numbered with proper numbered ID tag. Verification will occur between two nurses and/or trained or licensed staff at change of shift. Director of Nursing or designee will conduct random audits to ensure proper reconciliation, storage, and verification of E-Kit identification tag. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 30, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 0ZJD12

Dear Administrator:

The above facility was surveyed on April 23, 2021 through April 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING: _____ B. WING _____	C 04/09/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/5/21 - 4/9/21, a licensing and complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1	2 000		

have reviewed these orders, and identify the date when they will be completed.

The following complaints were found to be SUBSTANTIATED: H5517040C (MN00069120), H5517041C (MN00062982), H5517043C (MN00053863), however NO licensing orders were issued.

The following complaints were found to be UNSUBSTANTIATED: H5517042C (MN00061126) and H5517044C (MN00057214).

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for

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2 000	Continued From page 2 text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the	2 302		5/14/21

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2 302	Continued From page 3 training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 8 employees, licensed practical nurse (LPN)-B, registered nurse (RN)-A, and the administrator, received dementia or Alzheimer's training annually. This had the potential to affect all residents who resided in the facility. Findings include: During record review of annual dementia and Alzheimer training for 2020, three staff records were selected for the category of supervisors and five staff were selected for the category of direct care staff. Records indicated this training had not been completed for one staff in the category of supervisors (the administrator), and incomplete or not completed for two of five staff in the category of direct care staff (LPN-B and RN-A). During an interview on 4/9/21, at 10:30 a.m., the administrator stated that due to the Covid -19 pandemic, the facility was not able to ensure staff had time to complete the training. Staff have a new deadline of 4/30/21, to complete the training. If not completed by the deadline, those employees will be taken off the schedule until complete. SUGGESTED METHOD OF CORRECTION:	2 302	corrected	

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2 302	Continued From page 4 The director of nursing (DON) or designee could enroll all direct care staff in the appropriate Alzheimer's training courses and notify them of a timeline for completion. The DON could ensure all direct care staff complete the missed courses via an audit, and could develop a regular audit of facility education course completion to be done following new staff orientation and throughout the year as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide ongoing treatment for edema for 1 of 1 resident (R20), who required leg wraps and elevation to prevent and treat edema.	2 830	corrected	5/14/21

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2 830	Continued From page 5 Findings include: R20's Face Sheet printed 4/8/21, included diagnosis's of acute heart failure (heart muscle doesn't pump enough blood to meet body's demand), peripheral vascular disease (a circulation disorder that causes blood outside of heart and brain to narrow, block, or spasm), type 2 diabetes mellitus, chronic kidney disease stage 3 (moderate kidney damage), acquired absence of left leg below the knee and morbid obesity. R20s quarterly Minimum Data Set (MDS) assessment dated 2/5/21, included intact cognition with impairment of range of motion on one side of lower extremity with limb prosthesis. R20's provider orders dated 9/22/20, included compression to right leg in a.m.: Remove Rooke boot, moisturize leg with moisturizer in his room assessing for any alteration in skin integrity, notify provider if any skin problems occur. Apply knee immobilizer to right knee. Apply ACE wrap in figure 8, direction from toes to knees. Encourage resident to elevate legs as much as possible. A second order dated 12/29/20, included encourage resident to elevate legs every shift. R20's plan of care dated 10/15/20 included an alteration in skin integrity related to weakness and immobility post hospitalization related to left below the knee amputation. Intervention included compression to left extremity, encourage elevation of lower extremities as much as tolerated. Care plan also included a self-care deficit related to weakness related to left below the knee amputation with intervention including assist of one with personal hygiene and dressing. During observation and interview on 4/5/21, at	2 830		

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2 830	Continued From page 6 12:44 p.m., R20 was sitting in a recliner chair in his room with right leg dependant and foot on the floor, no ace wrap present and lower leg edema present. Skin was red from mid-calf to foot. Left leg was dependant also and a below the knee amputation present with no prosthesis on. R20 indicated he has a lot of swelling in his right foot and he is supposed to have his right leg wrapped in the morning when they remove his Rooke boot (vascular boot to naturally warm the limb) but it doesn't happen every day. R20 indicated he generally has to ask them to do it and then "half of the staff don't know how to do do I educate them on it when I have zero education in the medical field." R20 indicated the ace wrap really helps the swelling in his feet. R20 further stated the staff do not have time to remind him to keep his legs up as they are too busy for that. During observation on 4/6/21, at 9:29 a.m., R20 was asleep in his chair with legs dependant and ace wrap present on right lower leg. During interview on 4/6/21, at 2:26 p.m., R20 indicated he has not elevated his legs today. When asked if staff remind him he indicated no they don't have time for that. During interview and observation on 4/7/21, at 7:11 a.m. R20 was in recliner chair with both legs dependant with right foot on the floor while nursing assistant (NA)-G present in the room. Rooke boot remained on R20's right leg and ace wrap was present on R20's bed. R20 requested NA-G put on his wrap and NA-G grabbed his prosthesis. R20 stated "not that" and asked her to come back in 10 minutes and wrap his leg. R20 stated some of these staff just don't know what they are doing.	2 830		

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2 830	Continued From page 7 During interview on 4/7/21, at 7:22 a.m., NA-G indicated R20 can get upset when you ask him to elevate his legs so I don't ask him to do it. NA-G indicated she hasn't wrapped his leg before and will get another aide to assist with him with that. During interview and observation on 4/7/21, 9:31 a.m., NA-F indicated R20 gets upset when you ask him to elevate his legs, so I don't do it anymore. NA-F further stated he has a boot on in the mornings and then we wrap his leg when we take that off. During interview on 4/8/21, at 10:50 a.m., licensed practical nurse (LPN)-B, who is also the care coordinator, indicated R20 should be elevating his legs and she would expect staff to prompt him to put his legs up throughout the shift. During interview on 4/8/21, 11:33 a.m., the director of nursing (DON) indicated she would expect staff to remind R20 to raise his legs throughout the shift and to have his ace wrap put on in the mornings per orders. The DON did add she does she a lot of refusals documented for elevating his legs but was not aware staff are not reminding him. A policy on edema prevention and treatment was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for edema to ensure receiving necessary treatment and services. The director of nursing or designee could develop a system to conduct random audits of the delivery of care to ensure appropriate monitoring, care and services are implemented. The DON or designee could report results of audits to quality	2 830		

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2 830	Continued From page 8 assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to restore, maintain and prevent loss of range of motion (ROM) for 3 of 3 residents (R8, R2 and R21), reviewed for range of motion (ROM) and mobility. Findings include: R8 was admitted to the facility on 2/16, with diagnosis (identified on the diagnosis report sheet in the medical record) dated 4/9/21, that included: cerebral vascular accident (CVA) (stroke) polyneuropathy (malfunction of peripheral nerves	2 895	corrected	5/14/21

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2 895	Continued From page 9	2 895		

throughout the body) chronic kidney disease, osteoarthritis (arthritis in the joints) and fracture of the right femur.

Interview and observation on 4/7/21, at 9:00 a.m. R8 was observed sitting in a wheelchair in the lounge watching TV. R8's left hand was noted to be clenched and resting on his lap. When asked if he could open his right hand he was only able to open it partially. R8's 2nd, 3rd and 4th fingers noted to be slightly bent and the pinky finger was almost completely closed. R8 did not have a splint or any adaptive device to prevent contractures. R8 complained of discomfort when attempting to open his hand.

Observation on 4/8/21, at 12:00 p.m. R8 was observed eating dinner. R8 continued to have his left hand clenched tightly and resting in his lap. R8 was eating and moving items on his tray with his right hand and did not move his left hand or arm throughout the entire meal.

R8's quarterly Minimum Data Set (MDS) assessment dated 1/4/21, indicated R8 required extensive assistance with activities of daily living (ADL's). The MDS further indicated R8 did not have any impairment in ROM in the upper extremities. The MDS indicated R8 had severe cognitive impairment..

R8's care plan dated 1/13/21, identified R8 as having a self care deficit related to dementia and mobility deficits related to a CVA. R8 requires assistance with ADL's that included extensive assistance with upper extremity dressing. The care plan did not include R8's limited ROM in the left hand and fingers.

Review of R8's medical record did not include

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2 895	Continued From page 10 occupational therapy documentation or that R8 had ever received services for the left hand R8's current physicians orders dated 4/9/21, did not include any orders for therapy services, ROM or adaptive devices to prevent contractures in R8's left hand. Interview on 4/7/21, at 9;30 a.m. nursing assistant (NA)- B indicated R8 has kept his left hand and fingers closed for several months. NA-B stated R8 will complain of pain at times in his left hand when assisting him with dressing. NA-B further indicated there was no current treatment implemented for R8's left hand to prevent contractures or further impairment in ROM. During interview on 4/7/21, at 10:00 a.m. registered nurse (RN)-A confirmed R8 was unable to open his hand fully without staff assistance. RN-A also confirmed R8's fingers were difficult to open and the pinky finger could only be opened partially with assistance. RN-A stated R8 did not receive therapy services, ROM or adaptive devices to prevent contractures or worsening of limited ROM. Interview on 4/7/21, at 10:30 a.m. trained medication assistant (TMA)-A indicated R8 has had limited ROM is his left hand and fingers for several months. TMA-A confirmed R8 did not receive treatment to prevent contractures/further limited ROM in the left hand. TMA-A further indicated R8 always favors his left hand and has it closed resting on his lap. R2 R2's diagnosis report dated 4/9/21, indicated a	2 895		

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2 895	Continued From page 11 diagnosis of hemiplegia (paralysis of one side of the body) following a stroke. R2 had paralysis on the left side of his body. R2's annual Minimum Data Set (MDS) assessment dated 3/24/21, indicated R2 was cognitively intact, had adequate hearing and vision, clear speech, understood others and was able to make himself understood. R2 was dependent upon staff for bed mobility, transfers, dressing, toileting and hygiene. In addition, R2's care area assessment related to rehabilitation potential indicated staff would follow therapy recommendations for activity of daily living (ADL) function. R2 was able to self-propel his wheelchair in his room and hallways using his right arm. R2's orders reviewed in the electronic medical record (EMR) on 4/5/21, and dated 12/7/19, indicated R2 was to receive passive range of motion (PROM) to his left arm, and also upper body exercises with a weight in his right hand. The order indicated this was to occur every evening. R2's treatment administration record (TAR) reflected the same order. For the months of February, March and April 2021, the TAR indicated R2 received PROM every evening with the exception of three dates in February. R2's orders also indicated staff were to document refusals of care/treatments each shift. R2's plan of care, last reviewed on 1/6/21, indicated R2 would show improvement to the maximum potential for ADL's and would be free from signs and symptoms related to stroke, including contractures (tightening of muscles, tendons, ligaments or skin). The care plan did not address R2's left arm contracture, nor did it mention the PROM ordered on 12/7/19.	2 895		

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2 895	Continued From page 12 During an observation and interview on 4/5/21, at 2:40 p.m., R2's left wrist and elbow were observed. R2's left arm was flexed at the elbow and his right wrist was flexed at the wrist. R2 was not able to extend either his elbow or wrist. R2 stated he had the contractures for awhile, but not as tight as they were now. During an interview on 4/7/21, at 7:09 a.m. licensed practical nurse (LPN)-A stated they didn't really use a restorative binder (a resource where resident-specific PROM exercise sheets were kept for staff reference). LPN-A stated occupational therapy (OT) staff wrote orders for PROM and nursing assistants (NA's) performed it. When asked how a NA would know which PROM exercises to do with a resident if they didn't have a reference, LPN-A stated NA's had training on PROM. During an interview on 4/7/21, 7:15 a.m., when informed he had an order for PROM to occur in the evening, R2 stated "it may well be, but it's not being done." R2 stated he did not use weights to strengthen his right arm either. During document review, a nine page, untitled NA task sheet dated 4/7/21, indicated R2 was to receive PROM to his left arm, 10 times daily and upper body exercise with weight in right hand, daily. At the top of the form in bold, capital letters was "AMBULATION & ROM MUST BE DONE!!" During record review, a clinic visit dated 3/26/21, indicated R2 had hemiplegia from a stroke affecting his left side. Physical and occupational therapy were to evaluate, with the goal of increasing his strength so R2 could assist with ADL's.	2 895		

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2 895	Continued From page 13 During an interview on 4/7/21, at 8:06 a.m., occupational therapist (OT)-B stated R2 previously had OT services but when progress wasn't being made, he was put on a PROM plan for both upper extremities. OT-B stated OT wrote the order and NA's performed the PROM. OT-B went to R2's room to look for his PROM plan, (pictures of exercises individualized for R2). R2 stated he did not recall receiving a PROM exercise guide and was not able to locate it in his room. OT-B then returned to the nurses station and from a cupboard, retrieved a binder titled: East Wing Restorative Nursing Communication Book. OT-B stated OT placed all PROM plans for residents on the east wing (where R2 resided) in this binder. OT-B located R2's PROM exercises, dated 9/14/19, which indicated exercises to be done to left shoulder, arm, elbow, forearm, wrist and hand. In addition, exercises for the right hand included the use of a three pound weight. OT-B verified it was R2's most current plan. During an interview on 4/8/21, at 9:58 a.m., (LPN)-B stated NA's were supposed to do PROM on R2 in the evening. When asked how she accounted for R2 stating it wasn't being done when the TAR reflected it was, LPN-B stated nursing probably did not check with the NA, assumed the NA did it and just signed off on it. LPN-B added that R2 would not likely refuse PROM if offered. During an interview on 4/9/21, at 7:56 a.m. with (NA)-J and (NA)-I, both were aware R2 was to receive PROM, but neither worked the evening shift and stated they didn't know if R2 received or refused PROM. During an interview on 4/9/21, at 8:06 a.m., when	2 895		

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2 895	Continued From page 14	2 895		

asked how NA's know when a resident has PROM, (NA)-K stated therapy usually did the PROM, but sometimes NA's did it. NA-K removed a multiple page, untitled document from her pocket stating "we look at this and it will tell us." When asked if NA's provided PROM for R2, she looked at the sheet and pointed to R2's page which indicated PROM to left arm 10 times daily. NA-K stated R2's PROM was done in the evening and since she didn't work the evening shift, had not done it.

During an interview on 4/9/21, at 10:15 a.m., the director of nursing (DON) verified R2 was to receive PROM to his left arm, and upper body with a weight in his right hand. The DON stated nurses oversaw NA's to ensure PROM was being done. The DON reviewed R2's TAR and stated PROM was documented by a nurse as being done every day. The DON stated when a NA completed PROM, he/she informed the nurse and the nurse documented it on the TAR. The DON noted there were no PROM refusals documented in R2's record. When informed R2 stated PROM was not being done, the DON was unaware of this and admitted it was likely not being done, given R2 was cognitively intact and would know if it was not being done. The DON stated likely the nurse asked the NA if it had been done, but did not verify it had been done.

R21

R21's diagnosis report dated 4/9/21, indicated a diagnosis of hemiplegia (paralysis of one side of the body) following a stroke. R21 had paralysis on the left side of his body.

R21's quarterly Minimum Data Set (MDS) assessment dated 2/5/21, indicated R21 was

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2 895	Continued From page 15	2 895		

cognitively intact, had adequate hearing and vision, unclear speech, understood others and was able to make himself understood. R21 was dependent upon staff for bed mobility, transfers, dressing, toileting and hygiene. R21 was able to self-propel his wheelchair in his room and hallways using his right arm.

R21's physician orders initiated at the time of admission, included standing orders which indicated physical therapy (PT) and occupational therapy (OT) to evaluate and treat. R21's orders also indicated staff were to document refusals of care/treatments each shift.

R21's plan of care, last reviewed on 2/16/21, indicated R21 was to have gentle range of motion (ROM) daily, and the instructions for this were in the restorative book. In addition, R21 would remain free of complications or discomfort related to hemiplegia, would show improvement to maximum potential with mobility, and would improve current level of function as evidenced by needing less assistance with ADL's.

R21's treatment administration record (TAR), indicated R21 was to receive passive range of motion (PROM) in the morning and the instructions for this were in the restorative binder. According to the TAR, PROM exercises were done daily in February, March and April, 2021. No refusals were noted.

During an interview and observation on 4/5/21, at 2:12 p.m., R21 stated he did not receive PROM or therapy services, but he had in the past. R21's left arm was observed resting on a flat arm support attached to his wheelchair. R21 stated he had not been able to move his left arm since his stroke and had a lot of pain in that arm. R21's

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2 895	Continued From page 16 right hand was observed resting in a slightly clenched position. During an interview on 4/7/21, at 7:09 a.m. licensed practical nurse (LPN)-A stated they didn't really use a restorative binder (a resource where resident-specific PROM exercise sheets were kept for staff reference). LPN-A stated occupational therapy (OT) staff wrote orders for PROM and nursing assistants (NA's) performed it. When asked how a NA would know which PROM exercises to do with a resident if they didn't have a reference, LPN-A stated NA's had training on PROM. During an interview on 4/7/21, at 8:06 a.m., occupational therapist (OT)-B retrieved a binder from the nurses station titled: East Wing Restorative Nursing Communication Book. OT-B stated OT placed all PROM plans for residents on the east wing (where R21 resided) in this binder. OT-B located R21's PROM plan (exercises), dated 7/29/19, which indicated exercises to be done to both upper extremities to include elbows, wrists and hands. OT-B verified it was R21's most current plan. During an interview on 4/7/21, at 1:54 p.m., (NA)-L stated R21 received PROM to his left arm in the evening, but sometimes he refused due to severe pain. When this occurred, NA-L informed the nurse. During an interview on 4/8/21, at 9:58 a.m., (LPN)-B stated R21 should be receiving PROM, however the activity director who used to do it stopped due to Covid-19 concerns, and LPN-B didn't know if it had been resumed. During an interview on 4/8/21, at 11:25 a.m. R21	2 895		

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2 895	Continued From page 17	2 895		

and family member (FM)-C were in the activity room playing cribbage. FM-C expressed concern that R21's right hand was becoming contracted. FM-C took R21's hand and stated "look how his fingers are becoming clenched." Then FM-C manually opened R21's fingers. FM-C indicated awareness that R21 was not receiving PROM anymore and was not happy about it; expressing concern that R21's contractures and pain would worsen.

During an interview on 4/9/21, at 7:34 a.m., (NA)-A and (NA)-J were in R21's room to get him out of bed and dressed. NA-A stated R21 received PROM as it was listed on his care plan. NA-J stated therapy usually did the PROM, but sometimes nurses or NA's did it. NA-J stated they did R21's PROM when they got him out of bed... "we pull his arm back to stretch it out."

During an interview on 4/9/21, at 8:06 a.m., when asked how NA's know when a resident has PROM, (NA)-K stated therapy usually did the PROM, but sometimes NA's did it. NA-K removed a multiple page, untitled document from her pocket stating "we look at this and it will tell us." When asked if NA's provided PROM for R21, she looked at the sheet and pointed to R21's page which indicated: daily ROM to arms in AM. See Restorative communication book for OT recommendations. NA-K stated she had not taken care of R21 in a while, so had not done his ROM.

During an interview on 4/9/21, at 10:28 a.m., the director of nursing (DON) stated activities staff did R21's PROM. The DON was informed that according to LPN-B, activities staff stopped doing it some time ago due to Covid-19 concerns. The DON looked on the NA task bar (a list of NA tasks

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2 895	Continued From page 18 identified in the EMR) and it indicated R21 should have PROM to his left arm on Monday, Wednesday and Friday. The DON was informed that OT's recommendations indicated R21 should have PROM to both arms, one to two times per day, and that R21 and his wife stated no PROM exercises were occurring. The DON was informed FM-C was concerned this will result in more contractures and pain for R21. The DON admitted it was likely not being done, given the comments by R21 and FM-C. The DON assumed activities staff had been doing PROM. When asked how she accounted for R21 and FM-C stating PROM wasn't being done when the TAR reflected it was, the DON stated the nurse likely asked the NA if it had been done, but did not verify it had been done. The DON noted there were no PROM refusals documented in R21's record. During an interview on 4/9/21, at 12:37 p.m., the DON indicated she received R21's PROM exercise sheets from physical therapy assistant (PTA)-D which indicated R21 was to have PROM to both right and left arms one to two times per day. The DON admitted there were discrepancies between R21's plan of care, OT's recommended PROM exercises, the paper NA task sheet, and the NA task list in the EMR, and immediately sent an email to OT requesting them to evaluate and treat R21 for PROM. In addition, the DON added PROM to both extremities to the NA task list in the EMR to ensure it would get done. The facility policy titled Restorative Nursing Services, with revised date of July 2017, indicated the following: 1. Residents would receive restorative nursing care as needed to help promote optimal safety and independence.	2 895		

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2 895	Continued From page 19 2. Restorative nursing care consisted of nursing interventions that may or may not be accompanied by formalized rehabilitation services, such as OT. 3. Restorative goals and objectives were individualized and resident-centered, and were outlined in the residents plan of care. 4. The resident would be included in determining goals and the plan of care. 5. Restorative goals included maintaining dignity, independence, self-esteem and maintaining strength. The facility policy titled Resident Mobility and Range of Motion, with revised date of July 2017, indicated: 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited ROM will receive treatment and services to increase and/or prevent a further reduction in ROM. 3. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. 4. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives. 5. Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the residents condition or needs. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to implementation of range of motion, could assure proper assessment and interventions are being	2 895		

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2 895	Continued From page 20 implemented. The DON could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 1 resident (R84) reviewed who had a stage 4 pressure ulcer with known risks for pressure ulcer	2 900	corrected	4/12/21

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2 900	Continued From page 21 development. The facility's failures resulted in R84 sustaining harm when the resident developed an unstageable pressure ulcer to the left heel. Findings include: Pressure ulcer stages, identified from the National Pressure Ulcer Advisory Panel (NPUAP): Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuate) on the heel or scenic limb should not be softened or removed. R84 was admitted to the facility on 8/4/20, with diagnoses identified on the diagnosis report sheet including: diabetes mellitus, stage 4 pressure ulcer on the sacrum, kidney failure and protein calorie malnutrition. During observation and interview on 4/5/21, at 5:00 p.m. R84 was sitting in his wheelchair eating. R84 was noted to have a redistribution boot on the left foot and a sock on the right foot. R84's right heel was pressing against the foot pedal of the wheelchair. R84 stated he had a sore on his left heel, but was unsure about the right heel. R84 confirmed staff had been putting a protective device on only the left heel. R84 stated he had frequent pain in both heels. R84 further indicated he had an open sore on his coccyx area. Review of the Admission Data Collection sheet	2 900		

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2 900	Continued From page 22 dated 8/4/20, identified R84 as requiring extensive assistance with mobility, having clear speech, able to understand and able to be understood, with good memory recall. The admission skin assessment was left "blank" therefore not identifying R84's current skin condition. Review of a weekly wound evaluation dated 8/7/20, identified R84 as having a stage 4 pressure ulcer on the coccyx. The ulcer was identified as measuring 2.5 centimeters (cm) in length, 1.0 cm in width, and 2.5 cm in depth. The ulcer was further described as having full thickness tissue loss with adipose exposure, margins severely macerated (skin is soft and moist around the edges of a wound), wound edges slightly rolled, heavy yellowish drainage present, undermining (when tissue under the wound edges becomes eroded) and as having a foul odor. Interventions implemented included: pressure redistribution cushion on wheelchair, pressure relieving mattress and a repositioning schedule. In addition, the assessment indicated R84 was admitted with a significant pressure wound on 8/4/20, which was first assessed by facility staff 8/6/20. Review of a skin assessment dated 8/24/20, identified R84's left and right heels were "boggy". No other description of the heels was documented. In addition, no additional interventions were implemented to prevent breakdown of the heels. Review of a weekly wound evaluation dated 9/2/20, identified R84's left and right heels were "boggy". No other description of the heels was documented. Also, no additional interventions were implemented to prevent breakdown of the	2 900		

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2 900	Continued From page 23 heels. Review of a weekly wound evaluation dated 9/14/20, did not address R84's heels which had been identified to be "boggy" 8/24/20 and 9/2/20. There were no additional interventions identified to prevent breakdown of the heels. Review of a weekly wound evaluation dated 9/25/20, identified a suspected deep tissue injury to the left heel. Measurements were 3.4 cm in length, 5.5 cm in width and 0.0 cm in depth. The area was described as being purplish red in color and skin being soft and "boggy". Interventions implemented included: pressure redistribution boots on at all times and air mattress on bed. Although R84 was first identified as having "boggy" heels 8/24/20, no new interventions were implemented until this evaluation 9/25/20. Review of a weekly wound evaluation dated 10/12/20, identified R84's left heel as blistering and worsening. The evaluation indicated R84's heels and feet were pressing against the footboard of the bed. The pressure ulcer to the left heel was described as having partial tissue loss, discolored skin and scant serosanguinous drainage. Measurements were identified as 5.0 cm length by 4.5 cm width and 0.0 cm depth, and the wound was identified as unstageable. Review of R84's admission Minimum Data Set (MDS) assessment dated 8/7/20, identified R84 as having a baseline interview for mental status (BIMS) score of "15" (no cognitive impairment). The MDS identified R84 as requiring extensive assistance with bed mobility and positioning, indicated R84 as at risk for pressure ulcers, and indicated R84 had a current stage 4 pressure ulcer. Interventions included: pressure reducing	2 900		

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2 900	Continued From page 24 mattress, chair cushion, turn and repositioning program and pressure ulcer care. Review of R84's quarterly MDS assessment dated 2/2/21, identified R84 as having a BIMs score of "15." The MDS identified R84 as requiring extensive assistance with bed mobility and positioning, indicated R84 as at risk for pressure ulcers, and indicated R84 had a current stage 4 pressure ulcer, and an unstageable pressure ulcer. (The unstageable pressure ulcer was not present on admission) (right heel). Interventions included: air mattress, chair cushion, turn and repositioning program and treatment dressing. Review of the admission Braden scale dated 8/7/20, identified R84 as having mild to moderate risk for pressure ulcers. The assessment identified R84 as having a stage 4 pressure ulcer on the sacrum. In addition, R84 was identified to require extensive assistance with ADL's (activities of daily living) that included lifting legs in and out of bed. Interventions identified included: turning and repositioning program, redistribution cushion in chair, air mattress, weekly wound assessments and a protein supplement twice daily. Review of the R84's admission care plan dated 8/26/20, identified R84 as being at risk for skin breakdown related to acute kidney failure, limited mobility and current pressure ulcers. Interventions were identified as including: monitor skin integrity weekly, turn and reposition every 2 hrs (hours) and as needed (PRN), pressure redistribution cushion to chair, air bed, weekly wound measurement to sacrum and follow wound care. Review of the current plan of care dated 2/12/21,	2 900		

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2 900	Continued From page 25 identified R84 as having alteration in skin integrity related to pressure ulcers on the coccyx and left heel. Interventions included: offload left heel with a donut cushion at all times, weekly wound assessments, monitor skin daily, turn and reposition every 2 hours, pressure reduction cushion to chair, air mattress and encourage R84 to accept cares, due to occasional refusals. Review of the nursing assistant (NA) resident care sheet dated 4/2/21, indicated R84 requires assistance with ADLs, reposition every 2 hours/ remind the resident to reposition, may be up in chair no more than 2 hours at a time and blue heel donut to the left heel at all times. There were no preventative measures identified for the right heel. Review of the current physicians orders dated 4/8/21, included skin /pressure ulcer orders. These orders included: ensure heels are floated and pressure relief boots are in place. ensure feet are not rested on the foot board, weekly skin audits, wound care every 3 days and as needed to coccyx and wound care to left heel daily and off load at all times. During observation and interview on 4/6/21 at 4:00 p.m., R84 was observed to be sitting outside the facility with a staff person. R84 was in the wheelchair with both feet resting on the foot pedals. R84 was observed to have thick socks on both feet but did not have a redistribution device on either feet. R84 stated he was not sure if they were needed when he was up in his chair. During observation and interview on 4/8/21 at 11:00 a.m., R84's left heel pressure ulcer was measured by licensed practical nurse (LPN)-A. The left heel ulcer measured 5.6 cm by 5.0 cm by	2 900		

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2 900	Continued From page 26 0.0 cm. The area was identified by LPN-A to be covered with 80% eschar, 10% slough and 10% granulation. There was an increase in depth from the previous week, but the width and length had improved. During this time, R84 was resting in bed and noted to have a blue heel doughnut under the left heel, but did not have any kind of redistribution device under the right heel. The right heel was resting on the bed. The surveyor asked LPN-A to check the resident's right heel that was covered with a sock. LPN-A described the right heel as soft, slightly pink in color, with hardened skin around the edges. The center area measured a 1/4 inch of discoloration and blanchable. There were no visible open areas. R84 stated he was having pain in both feet. Interview with LPN-A at this time, confirmed R84 did not have any orders for a pressure redistribution device to R84's right heel and that there had been no previous redness in the area. LPN-A stated the wound nurse is currently responsible to monitor R84's skin. During interview on 4/7/21, at 9:30 a.m. NA-A and NA-B indicated R84 will reposition self most of the time, but staff need to remind him occasionally. NA-A and NA-B confirmed R84 was to have a blue heel donut to his left heel at all times when in bed. NA-A and NA-B also verified R84 did not have any kind of pressure reduction device for the right heel. NA-A and NA-B stated R84 utilizes the blue heel donut when in bed, but verified staff are not always able to place the donut properly when R84 is up in the wheelchair. During interview with RN-A on 4/8/21, at 1:00 p.m. RN-A confirmed R84 did not have orders for a pressure redistribution device to the right heel, even though R84 was at risk for pressure ulcers. RN-A confirmed R84's admission skin	2 900		

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2 900	Continued From page 27 assessment identified "boggy" heels with no interventions implemented, to prevent skin breakdown. RN-A verified after R84 was identified with "boggy" heels, R84 developed an unstageable pressure ulcer to the left heel 6 weeks later. The Director of Nursing (DON) and administrator were interviewed at 1:30 p.m. on 4/8/21. The DON confirmed R84 was admitted without a skin assessment completed until 3 days later. The DON also verified R84 was at risk for skin breakdown. The DON stated when R84's heels were identified to be "boggy" interventions should have been implemented. The DON further stated she would expect staff to assess the resident's skin on admission in order to determine interventions needed to prevent skin breakdown. The facility's 7/18 policy Skin Assessment and Wound Management, included: Initiate a weekly pressure wound evaluation when a pressure ulcer is identified, notify the wound nurse and update provider. Provide information regarding clinical identification of pressure ulcers/injuries and associated risk factors. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure comprehensive assessment/ interventions were placed and residents are receiving the necessary treatment/services to prevent pressure ulcers from developing and/or to promote healing of pressure ulcers. The DON or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer worsening and development. The DON or designee could report results of audits to quality	2 900		

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2 900	Continued From page 28 assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nail care was completed for 1 of 1 resident (R5) who required assistance with grooming, and were reviewed for activities of daily living. Finding include: R5's quarterly Minimum Data Set (MDS)	2 915	corrected	5/14/21

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2 915	Continued From page 29 assessment dated 12/29/20, indicated R5 had severely impaired cognition and required limited assistance with personal hygiene. R5's care plan printed 4/8/21, directed staff to check nail length and trim and clean on bath day and as necessary. Review of R5's Weekly Skin Inspections indicated the resident last had her nails trimmed on 3/9/21. On 4/5/21, at 4:10 p.m. R5 was observed seated in a wheelchair in her room. R5 had extremely long fingernails with some of them being jagged on the ends. R5 was unaware when her bath day was. R5 looked at her right thumbnail and stated, "This one needs to be trimmed". The thumbnail was jagged and had a v-shape out of part of the nail. On 4/6/21, at 2:52 p.m., 4/7/21, at 10:10 a.m. and 4/8/21, at 8:35 a.m. R5 was observed with long, jagged fingernails. When interviewed on 4/8/21, at 1:21 p.m. trained medication aide (TMA)-A stated residents routinely receive nail care on their bath day and as needed. TMA-A observed R5's fingernails and confirmed they were long and jagged. TMA-A further confirmed R5's bath day was on Tuesday evening (2 days prior) and nail care should have been completed at that time. When interviewed on 4/8/21, at 1:40 p.m. case manager/licensed practical nurse (LPN)-A confirmed nail care for residents should be completed on their bath day. Should the resident refuse their bath, they should still be reapproached for completion.	2 915		

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2 915	Continued From page 30 The policy titled, Bath, Shower/Tub, revised February 2018, did not address providing nail care at the time of a bath or shower. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents requiring assistance with grooming to assure they are receiving the necessary treatment and services. The director of nursing or designee could develop a system to conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The DON or designee could report results of audits to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grooming, timely toileting and incontinence cares were provided for 3 of 3 (R34, R41, R43) residents reviewed for activities of daily living (ADLs), who were dependent upon staff for care. Findings include:	2 920	corrected	5/14/21

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2 920	Continued From page 31 R34's admission Minimum Data Set (MDS) assessment dated 3/26/21, identified R34 as having severely impaired cognition and required extensive staff assistance with personal cares, that included grooming and shaving. R34's current care plan dated 12/22/20, identified R34 as requiring assistance of staff with personal hygiene that included grooming. R34 required assistance due to self care deficit related to quadriplegia, osteoporosis and cognitive disorder Review of the nursing assistant (NA) care sheet dated 4/6/21, directed staff to assist R34 with all ADL's During observation on 4/5/21, at 2:00 p.m. R34 was observed to have long facial hairs on the chin and upper lip. During observation and interview on 4/6/21, at 2:30 p.m. R34 was observed again to have long facial hairs on the chin and upper lip. R34 confirmed he was not growing a beard or mustache and would like to be shaved. During observation on 4/7/21, at 8:30 a.m.. R34 continued to have long facial hair on the chin and upper lip. During interview on 4/7/21, at 9:00 a.m. nursing assistant NA-A and NA-B indicated R34 is shaved on bath days which is on Mondays and Thursdays. NA-A and NA-B confirmed R32's facial chin and upper lip hairs were long and should have been shaved. NA-A and NA-B further indicated R34 was unable to shave independently and required daily staff assistance.	2 920		

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2 920	Continued From page 32 During interview on 4/7/21, at 9:00 a.m. NA-C confirmed R34 required staff assistance with shaving and should be shaved daily if needed. During interview on 4/8/21, at 10:00 a.m. licensed practical nurse (LPN)-A confirmed R34 requires daily assistance with ADL's. LPN-A further indicated the NA's should be checking R34 daily, and shaven when needed. During observation on 4/8/21, at 2:00 p.m. R34 continued to have long facial hair on the chin and upper lip. R41 R41's diagnosis report printed on 4/9/21, indicated diagnoses of Alzheimer's disease, Parkinson's disease, diabetes, chronic kidney disease, and weakness. R41's quarterly Minimum Data Set (MDS) assessment dated 3/18/21, indicated R41 had moderate cognitive impairment, adequate vision and hearing, clear speech, understood others and was able to make himself understood. R41 was dependent upon staff for bed mobility, transfers, locomotion on the unit, dressing, toileting and hygiene. In addition, R41 had an external urinary catheter, and was frequently incontinent of bowel. R41's plan of care, last reviewed on 4/6/21, indicated R41 had frequent bowel incontinence and was to be checked every two hours and as needed. R41 also had an alteration in elimination, was frequently incontinent of bladder and was to be toileted every two hours and as needed. R41 had an alteration in skin integrity and nursing staff were to keep his skin clean and dry, and his linen dry.	2 920		

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2 920	Continued From page 33 R41's order summary report printed on 4/9/21, indicated an order for a condom catheter; replace each morning and as needed. During document review, a nine page, untitled task sheet dated 4/7/21, indicated R41 was to be toileted every two hours and prn, and was to wear a condom catheter in bed. During document review, a physician note dated 3/4/21, indicated R41 had a nasty groin rash for several weeks and was using a condom catheter to attempt to keep the area dry, as he was incontinent of urine and stool. Skin: large pale pink area left medial thigh with slightly raised darker edges. Scrotum with irregular-shaped erythematous (red skin) rashes consistent with candida (yeast infection). Intertrigo (skin inflammation, usually in warm moist areas, such as the groin or between folds) groin. During document review, a nurse practitioner (NP) note dated 3/8/21, indicated R41 had a rash and redness to left thigh and groin. In the middle of prior week, the NP had been notified by staff that R41's rash was not improving; the probable cause of rash continued to be his urinary and fecal incontinence. A condom catheter trial was recommended to help manage R41's urinary incontinence. The following day, staff reported the trail of catheter went well. During an observation on 4/5/21, at 6:17 p.m., while R41 was in the dining room, a strong smell of urine was noted on his side of the room. R41's bottom fitted sheet had a round damp circle on it measuring approximately 12 inches in diameter. The incontinence pad had a damp area on it also, approximately 12 inches in diameter.	2 920		

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2 920	Continued From page 34 Daily Care Sheets for the south wing where R41 resided indicated the date and times residents were checked, changed or toileted. The times were hand-written on the sheet by NA's. There was no corresponding name or initials to indicate who toileted residents. On 4/6/21, the sheet indicated R41 was toileted at 2:00 p.m. However during a continuous observation from inside R41's room, or the hallway outside of R41's room from 1:29 p.m. to 3:48 p.m., no staff checked on him or toileted him. It wasn't until staff were asked to go into R41's room at 3:48 p.m. to check his brief, did he get toileted and changed. Observations and interviews on 4/6/21, include: --1:29 p.m., R41 was laying in bed watching TV. Room had a strong, foul odor of stool. --2:06 p.m., R41 was laying in bed with eyes closed. No one had come into R41's room, even though the foul odor was noticeable in the hallway outside of his room. --2:37 p.m., R41 was laying in bed with his eyes closed. --2:51 p.m., during an interview in the hallway outside of R41's room, nursing assistant (NA)-I stated she did not carry a NA task sheet. When asked how she knew the frequency at which a resident was to be repositioned or toileted, she stated she had that memorized. --3:02 p.m., during an interview in the hallway outside R41's room, when asked how she knew which residents required repositioning or toileting at specific intervals, (NA)-L removed a sheet from her pocket which indicated R41 should be toileted every two hours and as needed. --3:07 p.m., R41 was laying in bed with his eyes closed. No staff had come into his room since observation started at 1:29 p.m. despite foul odor	2 920		

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2 920	Continued From page 35 permeating the hallway. --3:16 p.m., trained medication aid (TMA)-A walked into R41's room to talk to his roommate. When asked if R41 participated in activities, TMA-A stated R41 didn't get out of bed except for meals. --3:44 p.m., when asked, NA-L stated R41 was last toileted at 2:00 p.m. according to the Daily Care Sheet. However, this was not observed during continuous observation. --3:48 p.m., NA-L was asked to check R41's brief. At R41's bedside, NA-L asked R41 if he needed to use the bathroom and he replied no. Strong, foul odor in room persisted. When NA-L checked R41's brief, it was saturated with urine and stool. When asked how it could be saturated with urine when R41 had a condom catheter, NA-L stated R41 tended to pull the catheter off. Noted R41's catheter was not in place when NA-L pulled back his brief. NA-L got R41 out of bed, into a wheelchair and into the bathroom. R41's fitted sheet had been soiled with urine and stool, his brief had been soiled with urine and stool, as were the cloth underwear with snaps that were over his brief, as were the rust colored sweat pants he was wearing. R41's coccyx was observed to have a reddened area about the size of a hand which appeared raised and bumpy. Redness was noted in his groin also. While R41 was sitting on the toilet, NA-L stripped the bed and replaced the sheets and incontinent pad. The bare rubber mattress was not cleaned prior to placing clean sheets on the bed. Licensed practical nurse (LPN)-A went into the bathroom to replace R41's condom catheter. LPN-A stated the condom catheter gets pulled off when R41 moves, adding that R41's urine was toxic to his skin and that was why he wore the condom catheter. After being cleaned up in the bathroom, a clean brief and sweat pants were put on, and	2 920		

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2 920	Continued From page 36 R41 was assisted back into the wheelchair. During an observation on 4/7/21, at 7:44 a.m., R41 was laying in bed with eyes closed; sheet partially covering him; wearing just a brief and the same sweatshirt from the day before. Room smelled of urine. During an observation and interview on 4/7/21, at 9:20 a.m., (NA)-F and (NA)-G entered the room to get R41 up for breakfast. Observed R41's brief to be saturated with yellow urine when NA-F removed it. NA-F stated R41's condom catheter had fallen off. NA-F did not know when R41's brief had been checked or changed last. According to the Daily Care Sheet, his brief had been checked 8:30 a.m. and was dry (40 minutes prior to NA-F finding it saturated with urine). TMA-A came into R41's room and replaced his condom catheter. A new condom catheter was applied, which was attached to drainage tubing, which was attached to a urinary drainage bag. The drainage tubing was secured to R41's left leg with an elastic and Velcro strap. There was not enough give to the tubing -- if the strap slid down it could pull the condom catheter off. (NA)-G stated "we are constantly changing his condom catheter because it falls off." As NA-F continued to wash R41's groin, it was noted to be red. NA-F commented "it's pretty bad; I know it's sore." When R41 was turned, observed further redness on his coccyx and left posterior thigh. As R41 was assisted into a wheelchair for breakfast, observed bottom sheet, incontinence pad and disposable absorbent pad to be damp, which was verified by NA-F, but not changed. At 10:50 a.m., R41 returned from breakfast and was assisted into bed with the same soiled bedding still in place. During an interview and observation on 4/7/21, at	2 920		

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2 920	Continued From page 37 1:30 p.m., R41 was returned to his room after lunch by NA-F who stated resident bed linen was changed once a week after their bath. As NA-F assisted R41 into bed, she noticed the soiled bedding and changed it. The bare rubber mattress was not cleaned prior to this. When asked if the condom catheter was still in place, NA-F stated it was, however when she removed his pants to his check brief, it came off. TMA-A came to the room to replace it. TMA stated when they first started using the catheter, his skin had improved, but it was worse again..."it's better than it was, but it's still not pretty." During an interview and observation on 4/8/21, at 8:22 a.m., a very strong smell of urine was noted in the hallway outside R41's room and in his room. At 9:16 a.m., NA-F entered the room to get R41 up for breakfast. NA-F looked in R41's brief and stated the condom catheter was off again and his brief was saturated with urine. NA-F removed the brief and washed R41's perineal area. The condom catheter was replaced by TMA-A. Discussed leg strap with TMA-A and the short distance between catheter and strap which appeared to be the cause for the catheter frequently being pulled off. TMA-A stated they were looking into a different device to secure the tubing to prevent the condom catheter from being pulled off. During an interview on 4/8/21, at 9:58 a.m., licensed practical nurse (LPN)-B stated R41 was able to toilet himself; mostly for bowel movements, and added staff should be checking on him every two to three hours, checking either his brief or toileting him. LPN-B stated now that R41 had a condom catheter, it was easier to check R41. When asked when R41 was last toileted, she looked at the Daily Care Sheet for	2 920		

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2 920	Continued From page 38	2 920		

toileting and stated 5:15 a.m., adding she would have expected R41 to be looked at again between 7:00 a.m. and 8:00 a.m. LPN-B was informed he had not been looked at until 9:15 a.m. LPN-B stated NA's likely gave R41 a longer period of time since he had a condom catheter now, but should be looking for incontinent bowel movements sooner. Daily Care Sheets for toileting where reviewed with LPN-B for residents on the south unit were R41 resided. It was pointed out to LPN-B that on 4/6/21, 15 residents were checked, changed or toileted at 2:00 p.m. On 4/7/21, nine residents were checked, changed or toileted at 9:00 a.m., and seven residents at 11 a.m. With three or four NA's on the south unit, was it possible to check, change and toilet that many residents at the same time? LPN-B stated those times were likely not the exact times the activity occurred, as NA's don't document on the sheet right after the task was performed.

During an observation and interview on 4/9/21, at 8:44 a.m., R41 was laying in bed. At 9:47 a.m., he was still in bed. At 9:49 a.m., LPN-B was asked when the last time R41's brief had been checked or he was toileted and she replied she didn't know because it was not documented on the Daily Care Sheet. As R41's room was entered with LPN-B, without prompting, R41 stated "I'm being ignored." LPN-B asked him if he had been to breakfast yet, or if staff have been into his room yet and R41 replied no. When LPN-B pulled back R41's sheet, his brief, cloth underpants and sweat pants were visibly wet and R41's condom catheter was off again. At 10:04 a.m., (NA)-D came into the room and stated R41 had refused to have his brief checked and refused to get up when checked on earlier. LPN-B stated she expected staff to physically check a residents brief for someone like R41 who had Alzheimer's

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2 920	Continued From page 39 disease, not just ask if he needed to be changed, adding R41 was not always able to communicate his needs accurately. During an interview on 4/9/21, at 11:01 a.m., the DON stated R41 was to be checked, changed or toileted every two hours and as needed. The DON stated R41 might refuse or deny he needed to be changed, but due to his cognitive level, she would expect staff to still check his brief. The DON was not aware R41 was not being checked, changed or toileted every two hours and stated it was her expectation staff followed R41's plan of care. The DON was not not aware of the frequency of R41's condom catheter coming off until recently, and stated they were looking into a more secure device to prevent this. When asked if staff routinely investigated strong odors of urine to determine the source, whether it was a saturated brief, soiled mattress or carpeting, the DON stated staff probably didn't notice the smells and admitted they could do a better job of this. The DON stated R41's mattress as well as another residents mattress had been replaced on 4/8/21, due to retaining the odor of urine. R43 R43's Face Sheet printed 4/8/21, included diagnoses of Alzheimer's, Epilepsy, dementia, anxiety, weakness and neuromuscular dysfunction of the bladder. R43's annual Minimum Data Set (MDS) assessment dated 3/18/21, indicated R43 had severe cognitive impairment, does not speak, is rarely understood and rarely understands, requiring extensive assist of two for bed mobility, transfers, and personal hygiene.	2 920		

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2 920	Continued From page 40 R43's care plan dated 3/28/21, indicated R43 was totally dependent on staff for toilet use. An additional care plan dated 7/17/18, indicated an alteration in elimination related to Alzheimer's and included a toileting plan for checking and changing every two hours and as needed. During observation and interview on 4/5/21, at 5:34 p.m., family member (FM) indicated he has asked them to allow R43 to rest in bed after meals and to wake R43 about an hour before meals and to check and change her as needed so she is awake before he comes to assist her to eat, but they don't do it and stated "I guess it is part of the way it just is." R43 was continually observed on 4/7/21: 7:30 a.m., R43 brought out to the common sitting room from the dining room and placed in front of the television. 8:00 a.m., R43 dozing in chair without position change. No staff approached R43. 8:20 a.m., R43 remains in common sitting room, dozing in her chair. No staff have approached R43. 8:50 a.m., R43 remains sitting in common room in her wheelchair. No staff have approached R43. 9:15 a.m., R43 remains in common room dozing in her wheelchair. No staff have approached R43. 9:45 a.m., R43 remains in common room, no position changes and no staff have approached R43. 10:15 a.m., R43 remains in common room, no position changes and no staff have approached R43. 10:46 a.m., R43 remains sitting in the common room and no staff have approached R43. 10:52 a.m., R43 remains in common room, no	2 920		

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2 920	Continued From page 41 position changes and no staff have approached R43. 11:15 a.m., R43 remains in common room, no position changes and no staff have approached R43. 11:54 a.m., R43 remains in common room, no position changes and no staff have approached R43. 12:10 p.m., R43 family member arrived and R43 moved to the dining room. Staff assisted resident to dining room, but did not toilet her. 12:55 p.m., R43 remains in dining room with family member. 1:10 p.m., R43 was moved back to the common room, remained seated in her wheelchair, was not toileted and placed in front of the television after family member left. 1:38 p.m., R43 remains in the common room, no repositioning or toileting completed. 1:59 p.m., the administrator approached and spoke to R43 and then requested staff lay her down for awhile as R43 appeared tired. During interview on 4/7/21, at 1:22 p.m., a family member (FM) indicated he has requested R43 be put back in her bed in the morning for awhile so she isn't so tired when he comes to assist her to eat, but they don't listen to me. FM further indicated it is easier for them to leave her in her chair and sit her out in the area by the nurses station (common area) to keep an eye on her but is concerned they don't reposition or toilet her. FM indicated he has spoken to the facility many times about this issue and is very frustrated that it doesn't get done. During observation and interview on 4/7/21, at 2:02 p.m., nursing assistant (NA)-A and NA-B, wheeled R43 to her room and using mechanical lift transferred R43 to her bed and checked	2 920		

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2 920	Continued From page 42	2 920		

incontinent pad. R43 had a large brown formed stool in incontinent pad with stool dried to the skin around the edges. NA-A was questioned when R43 was last toileted indicated she was unsure and would have to check. Skin was red after using wipes to clean dried stool off buttocks.

During interview on 4/7/21, at 2:19 p.m., NA-A indicated she was repositioned at 6:30 a.m., and 8:30 a.m., but not since then but should have been checked on and repositioned at 10:30 a.m. and 12:30 p.m.

During interview on 4/8/21, 8:28 a.m., NA-C indicated they try to lay down R43 in the mornings and check her pad, but it doesn't always happen if they are short staffed. NA-C indicated she is aware the family member has requested R43 lay down between meals.

During interview on 4/08/21, 11:36 a.m., the director of nursing (DON) confirmed she would expect staff to follow the plan of care and if it states every two hours, they should check and change the resident every two hours.

The facility policy titled Activities of Daily Living (ADLs), Supporting, with revised date of 3/2018, indicated:
1. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.
2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent and in accordance with the plan of care, including support and assistance with elimination (toileting).
3. If residents with cognitive impairment or dementia resist care, staff will attempt to identify

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2 920	Continued From page 43 the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. The DON or designee could report results of audits to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.	2 930		5/14/21

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2 930	Continued From page 44 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure placement of gastronomy tube (G-tube) tube inserted through the abdomen delivering nutrition and medication directly into the stomach) before giving medications to 1 of 1 resident (R34) observed with a G-tube. Findings include: R34's quarterly Minimum Data Set (MDS) assessment dated 3/10/21, indicated R34 had severe cognitive impairment with diagnoses including traumatic brain injury. The MDS further indicated R34 was totally dependent on staff for all activities of daily living. R34's care plan printed 4/7/21, indicated a potential for alteration in nutrition related to need for tube feeding for total nutrition secondary to diagnoses of quadriplegia, epilepsy, and dysphasia. Interventions included to check placement of G-tube prior to meds and feedings with stethoscope. R34's current physician orders printed 4/7/21, indicated: Check for G-tube placement prior to meds and feedings with stethoscope. Two times a day AND four times a day. On 4/7/21, at 10:50 a.m. licensed practical nurse (LPN)-A was observed setting up medications and nutritional feeding via G-tube for R34. Prior to administering the medications and feeding, LPN-A attached a 60 cubic centimeter (cc) syringe to the end of R34's G-tube and pulled back to check for residual. LPN-A then proceeded to administer R34's medications	2 930	corrected	

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2 930	Continued From page 45 followed by his feeding. When interviewed following administration, LPN-A confirmed ensuring placement of R34's G-tube by checking the residual. LPN-A stated if the residual was greater than 150 cc's the feeding would be held. When interviewed on 4/9/21, at 11:24 a.m. the director of nursing (DON) confirmed checking placement of a resident's G-tube should be performed through auscultation (listening to sounds arising within organ) with a stethoscope and also checking for residual through the tube. The policy titled Enteral Tube Medication Administration, dated April 2018, indicated: With gloves on, check for proper tube placement using air and auscultation only. Never check placement with water. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident with feeding tubes are monitored for proper placement of that feeding tube. The DON or designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance. The DON or designee could report results of audits to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency	21600		5/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00038	A. BUILDING: _____ B. WING _____	C 04/09/2021

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21600	Continued From page 46 medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for periodic reconciliation of controlled or narcotic medications in 1 of 1 emergency kit (E-Kit) to prevent potential loss or diversion. This had the potential to affect any of the 52 residents present in the facility who may require controlled medications from the E-Kit. Findings include: On 4/9/21, at 9:20 a.m., a tour of the North unit medication room was conducted with licensed practical nurse (LPN)-B. Located within the medication room was a refrigerator with an E-Kit with a green unnumbered tag present that included lorazepam (an anti-anxiety medication/controlled substance). LPN-B indicated if the E-Kit is opened and something taken out, they put a red numbered tag back on kit until the pharmacy comes to change out the E-Kit. LPN-B was unsure how often pharmacy comes to the facility. LPN-B further indicated she is aware lorazepam is in the E-Kit but indicated they do not count it daily with the narcotic counts. On 4/9/21 at 10:08 a.m., review of the narcotic log book on the North unit, did not include lorazepam from the E-Kit. During interview on 4/9/21, at 9:36 a.m., the director of nursing indicated the E-Kit gets	21600	corrected	

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21600	Continued From page 47 replaced every Monday, and confirmed the lorazepam is not getting counted every day. The policy titled, Controlled Medication Storage, dated 4/14, included: If a scheduled III, IV, and V medication is not supplied in a unit dose automatic exchange system, the facility must implement an accountability record system. At each shift change, a physical inventory of all controlled medications is conducted by 2 authorized medication passers. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) consultant pharmacist or designee could review and revise policies and procedures to include processes for monitoring controlled substances stored in the E-Kit. The administrator, DON, consultant pharmacist or designee could perform random observational audits to ensure compliance. The administrator, DON or designee could report results of audits to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21600		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced	21805		5/14/21

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21805	Continued From page 48 by: Based on observation, interview and document review, the facility failed to provide a dignified atmosphere for 1 of 1 resident (R43) observed to have an uncovered catheter bag which was visible to others. Findings include: R43's Face Sheet, undated indicated R43 had a diagnosis of neuromuscular dysfunction of the bladder that can cause retention, Alzheimer disease and dementia. R43's annual Minimum Data Set (MDS) assessment dated 3/18/21, indicated R43 had severe cognitive disorder, does not speak, is rarely understood and requires extensive assist of two for transfers and bed mobility, is totally dependant on staff for locomotion and has an indwelling catheter. During observation and interview on 4/5/21, at 5:34 p.m., R43 was wheeled down a hallway in a wheelchair past the common room (television, computer and activities area), where four other residents were sitting, to the dining room without a cover on on the urine collection device (catheter bag). A family member (FM) indicated R43's catheter bag is never covered. He just notices the color of urine when he is here, but it doesn't bother him. FM further indicated if R43 still had her thought process, it would bother her. During observation on 4/5/21, at 6:30 p.m., R43 was wheeled to the common area with the catheter bag uncovered under her chair and visible. Five other residents were present in the common room area.	21805	corrected	

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21805	Continued From page 49 During observation on 4/6/21 at 2:18 p.m., R43 was in the common area in her wheelchair with uncovered catheter bag under the chair and visible. Six other residents were present as bingo was being played at this time. During observation on 4/7/21 at 7:09 a.m., R43 was in the common room with three other residents with uncovered catheter bag attached under the wheelchair and visible. During interview on 4/7/21, at 2:02 p.m., nursing assistant (NA)-a indicated most catheter bags come with a cover but this one must not have, but generally they have the catheter bags covered. During observation on 4/8/21, at 8:22 a.m., R43 was wheeled from the main dining area with multiple residents present, down the hallway to the common area with catheter bag under the wheelchair uncovered and visible. During observation and interview on 4/8/21, at 10:38 a.m., NA-E wheeled R43 down hallway to R43's room and was assisted by NA-D using lift to assist R43 to her bed. NA-D indicated generally when residents are taken out of their rooms the catheter bag is covered. NA-D further added that some catheter bags come with a cover and others don't and apparently this one didn't. During interview on 4/08/21, at 11:36 a.m., the director of nursing confirmed catheter bags should be covered when residents leave their rooms or is visible. A policy and procedure related to ensuring catheter bags are covered was requested and not provided.	21805		

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21805	Continued From page 50 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents with indwelling Foley catheters. The director of nursing or designee could develop a system to conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The DON or designee could report results of audits to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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

PRINTED: 05/25/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Oaklawn Care and Rehab 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. "IF OPTING TO USE EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED" PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2021

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

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

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K 000	Continued From page 2 department notification. The facility has a capacity of 70 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 321		5/14/21

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K 321	Continued From page 3 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazard rooms NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, 19.3.6.3.5. This deficient practice could affect all residents within the smoke compartment. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 04/08/2021, observation revealed that the North Soiled Linen Room door did not positively latch when closed. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 321	North Soiled Linen Room door was repaired to ensure it was positively latching when closed. Education provided to all staff regarding the importance of ensuring the linen room doors are positively latching when closed. Maintenance Director or designee will conduct random audits to ensure facility linen room doors are positively latching when closed. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	