5

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: OVK0

PART	- TO BE COMPLETE	D BY THE STAT	E SURVEY AGENCY	Facility ID: 00038
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245517 2.STATE VENDOR OR MEDICAID NO. (L2) 953692000 (L2)	3. NAME AND ADDRESS ((L3) OAKLAWN CARE ((L4) 201 OAKLAWN AV (L5) MANKATO, MN	& REHABILITATI	ON CENTER (L6) 56001	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
 EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 07/01/2015 	7. PROVIDER/SUPPLIER (01 Hospital 05 HH		<u>02</u> (L7) 13 PTIP 22 CLIA	 On-Site Visit Other Full Survey After Complaint
6. DATE OF SURVEY 05/20/2021 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual06 PR03 SNF/NF/Distinct07 X-F04 SNF08 OP	Ray 11 ICF/IID	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 70 (L18) 13.Total Certified Beds 70 (L17) 14. LTC CERTIFIED BED BREAKDOWN 19 SNF 18 SNF 18/19 SNF 19 SNF 70 (L37) (L38) (L39)	10.THE FACILITY IS CERT X A. In Compliance With Program Requireme Compliance Based 1. Acceptabl B. Not in Compliance Requirements and/or Ap ICF (L42)	ents On: e POC with Program oplied Waivers: IID (L43)	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
 STATE SURVEY AGENCY REMARKS (IF APPLICAB SURVEYOR SIGNATURE Elizabeth Silkey, Unit Supervisor 	Date :		18. STATE SURVEY AGENCY A Melissa Poepping, Enfo	
PART II - TO B	E COMPLETED BY HO	CFA REGIONAL	OFFICE OR SINGLE STA	ATE AGENCY
 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21) 	20. COMPLIANC RIGHTS AC			ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREEN OF PARTICIPATION BEGINNING 02/01/1988 (L41) 25. LTC EXTENSION DATE: 27. ALTERNAT A. Suspension Automatical	DATE END	AGREEMENT ING DATE	26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change
(1.27)	(L4 spension Date:			00-Active
28. TERMINATION DATE: 2	9. INTERMEDIARY/CARRIER	R NO.	30. REMARKS	
(L28)	06201	(L31)		
31. RO RECEIPT OF CMS-1539 3	2. DETERMINATION OF APPR	OVAL DATE		
(L32)		(L33)	DETERMINATION APPRO	DVAL



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,

· Juig

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



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,

Mitig

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



Protecting, Maintaining and Improvingthe 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,

Mighing

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 & MI	EDICAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: OVK0
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00038

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	GENCY		Facility ID: 00038	
1. MEDICARE/MEDICAID PROVIDER NO. (L1)3. NAME AND ADDRESS OF FACILITY (L3)245517(L3)					TION CENTE	R	 4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 		
2.STATE VENDOR OR MEDICAID N	Ю.	(L4) 201 OAKLA	WN AVENUE				1. Initial 3. Termination	2. Recertification 4. CHOW	
(L2) 953692000		(L5) MANKATO	, MN		(L6)	56001	5. Validation	6. Complaint	
5. EFFECTIVE DATE CHANGE OF ((L9) 07/01/2015	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	 7. On-Site Visit 8. Full Survey At 	9. Other fter Complaint	
6. DATE OF SURVEY 04/09	/ 2021 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF				
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR EN	DING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		09/30		
11LTC PERIOD OF CERTIFICATION	1	10.THE FACILITY	IS CERTIFIED	AS:					
From (a):		A. In Complia					The Following Require		
To (b):			equirements e Based On:			nical Personnel	_ 6. Scope of		
					3. 24 H		7. Medical		
12.Total Facility Beds	70 (L18)	1. A	cceptable POC			y RN (Rural SN)			
13.Total Certified Beds	70 (L17)	X B. Not in Con	npliance with Prog	gram	5. Life	Safety Code	9. Beds/Roo	om	
		Requirements	and/or Applied V	Waivers:	* Code:	B*	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY N	MEETS			
18 SNF 18/19 SNF 70	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION 1	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY	APPROVAL	Date:	
Wendy Buckholz, HFE	NE II	0	5/24/2021	(L19)	Melissa Poep	ping, Enforce	ement Specialist	06/03/2021 (L20)	
PAI	RT II - TO BE	COMPLETED H	BY HCFA RE	EGIONAL	OFFICE OR	SINGLE ST	TATE AGENCY		
19. DETERMINATION OF ELIGIBIL	ITY		IPLIANCE WITH HTS ACT:	H CIVIL			cial Solvency (HCFA-2 l Interest Disclosure St		
1. Facility is Eligible to P	articipate	iuo.				oth of the Above		()	
2. Facility is not Eligible	(L21)								
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT					
OF PARTICIPATION					26. TERMINA	FION ACTION:		(L30)	
	BEGINNING	G DATE	ENDING DA	TE	26. TERMINA <u>VOLUNTARY</u>		INVOL	(L30) UNTARY	
02/01/1988	BEGINNING	G DATE	ENDING DA	ТЕ		00		· · ·	
02/01/1988 (L24)	BEGINNING (L41)	G DATE	ENDING DA	ГЕ	VOLUNTARY	00	05-Fail	UNTARY	
	(L41)	G DATE		TE	<u>VOLUNTARY</u> 01-Merger, Close	 ure n W/ Reimburse	05-Fail ment 06-Fail	UNTARY to Meet Health/Safety to Meet Agreement	
(L24)	(L41) 27. ALTERNATI			TE	<u>VOLUNTARY</u> 01-Merger, Closs 02-Dissatisfactio	 ure n W/ Reimburse ntary Termination	05-Fail ment 06-Fail ¹ <u>OTHEF</u>	UNTARY to Meet Health/Safety to Meet Agreement	
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(L24)	(L41) 27. ALTERNATI A. Suspensio	VE SANCTIONS	(L25)	ΓE	VOLUNTARY 01-Merger, Close 02-Dissatisfactio 03-Risk of Involu	 ure n W/ Reimburse ntary Termination	05-Fail ment 06-Fail 1 <u>OTHEF</u> 07-Prov	UNTARY to Meet Health/Safety to Meet Agreement C	
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI A. Suspensio	VE SANCTIONS n of Admissions:	(L25)	ГЕ	VOLUNTARY 01-Merger, Close 02-Dissatisfactio 03-Risk of Involu	 ure n W/ Reimburse ntary Termination	05-Fail ment 06-Fail 1 <u>OTHEF</u> 07-Prov	UNTARY to Meet Health/Safety to Meet Agreement C	
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI A. Suspensio B. Rescind S	VE SANCTIONS n of Admissions:	(L25) (L44) (L45)	TE	VOLUNTARY 01-Merger, Close 02-Dissatisfactio 03-Risk of Involu	 ure n W/ Reimburse ntary Termination	05-Fail ment 06-Fail 1 <u>OTHEF</u> 07-Prov	UNTARY to Meet Health/Safety to Meet Agreement C	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATI A. Suspensio B. Rescind S	VE SANCTIONS n of Admissions: uspension Date:	(L25) (L44) (L45)	TE	VOLUNTARY 01-Merger, Close 02-Dissatisfactio 03-Risk of Involu 04-Other Reason	 ure n W/ Reimburse ntary Termination	05-Fail ment 06-Fail 1 <u>OTHEF</u> 07-Prov	UNTARY to Meet Health/Safety to Meet Agreement C	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATI A. Suspensio B. Rescind S	VE SANCTIONS n of Admissions: uspension Date:). INTERMEDIARY/	(L25) (L44) (L45)	(L31)	VOLUNTARY 01-Merger, Close 02-Dissatisfactio 03-Risk of Involu 04-Other Reason	 ure n W/ Reimburse ntary Termination	05-Fail ment 06-Fail 1 <u>OTHEF</u> 07-Prov	UNTARY to Meet Health/Safety to Meet Agreement C	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATI A. Suspensio B. Rescind S 29 (L28)	VE SANCTIONS n of Admissions: uspension Date:). INTERMEDIARY/	(L25) (L44) (L45) CARRIER NO.	(L31)	VOLUNTARY 01-Merger, Close 02-Dissatisfactio 03-Risk of Involu 04-Other Reason	 ure n W/ Reimburse ntary Termination	05-Fail ment 06-Fail 1 <u>OTHEF</u> 07-Prov	UNTARY to Meet Health/Safety to Meet Agreement C	



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: 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 Oaklawn Care & Rehabilitation Center April 30, 2021 Page 3

> 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

Oaklawn Care & Rehabilitation Center April 30, 2021 Page 4

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 <u>Tamika.Brown@cms.hhs.gov.</u>

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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:

Oaklawn Care & Rehabilitation Center April 30, 2021 Page 5

> 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,

M. Ping

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

					0		APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED
		245517	B. WING				C 09/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	VN CARE & REHABIL	ITATION CENTER			01 OAKLAWN AVENUE IANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
	Appendix Z, Emerg Requirements, §48	a survey for compliance with ency Preparedness 3.73(b)(6) was conducted ecertification survey. The pliance.					
F 000	signature is not req page of the CMS-22 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents. TS	F0	00			
	survey was conduc investigation was a was found to be NC requirements of 42	, a standard recertification ted at your facility. A complaint lso conducted. Your facility DT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.					
	SUBSTANTIATED: H5517041C (MN00 (MN00053863), how	plaints were found to be H5517040C (MN00069120), 0062982), H5517043C wever NO deficiencies were a implemented by the facility					
	UNSUBSTANTIATE	blaints were found to be ED: H5517042C H5517044C (MN00057214).					
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 05/10/2021
Electron	ilcally Signed						03/10/2021

Electronically Signed

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.

DEDADTMENT OF LIFALTLAND LUMANN OF DVICES

		AND HUMAN SERVICES				FORM	: 05/19/2021 APPROVED . 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	COM	E SURVEY IPLETED C
		245517	B. WING				09/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	N CARE & REHABIL	ITATION CENTER		_	201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	Continued From pa	ge 1	F	000			
	be used as verificat	tion of compliance.					
F 550 SS=D	onsite revisit of you	ercise of Rights	F	550			5/14/21
	self-determination, access to persons a	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
	with respect and dig resident in a manner promotes maintena her quality of life, re	ility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident.					
	access to quality ca severity of condition must establish and practices regarding provision of service	facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source.					
		e right to exercise his or her of the facility and as a citizen					
	§483.10(b)(1) The f	facility must ensure that the					

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		AND HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
			A. DOILDI	<u> </u>		(C
		245517	B. WING _				09/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	/N CARE & REHABIL	ITATION CENTER			1 OAKLAWN AVENUE ANKATO, MN 56001		
				IVI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From pa resident can exercis interference, coerci from the facility. §483.10(b)(2) The r free of interference, reprisal from the fac rights and to be sup exercise of his or he subpart. This REQUIREMEN by: Based on observat review, the facility fa atmosphere for 1 of have an uncovered visible to others. Findings include: R43's Face Sheet, f diagnosis of neuron bladder that can can disease and demen R43's annual Minim assessment dated 3 severe cognitive dis rarely understood a two for transfers an dependant on staff indwelling catheter. During observation 5:34 p.m., R43 was	ge 2 se his or her rights without on, discrimination, or reprisal resident has the right to be , coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced ion, interview and document ailed to provide a dignified f 1 resident (R43) observed to catheter bag which was undated indicated R43 had a nuscular dysfunction of the use retention, Alzheimer ntia. num Data Set (MDS) 3/18/21, indicated R43 had sorder, does not speak, is nd requires extensive assist of d bed mobility, is totally for locomotion and has an	F 5	50		led with ure theter ng d r all	
	residents were sittir	ities area), where four other ng, to the dining room without rine collection device (catheter					

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	-	AND HUMAN SERVICES			FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245517	B. WING			C 09/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550	bag). A family men catheter bag is new the color of urine will bother him. FM fur her thought process During observation was wheeled to the catheter bag uncov visible. Five other r common room area During observation was in the common uncovered catheter visible. Six other re was being played a During observation was in the common residents with unco under the wheelcha During interview on assistant (NA)-a ind come with a cover b generally they have During observation was wheeled from t multiple residents p the common area w wheelchair uncover During observation 10:38 a.m., NA-E w R43's room and wa to assist R43 to her	hber (FM) indicated R43's er covered. He just notices hen he is here, but it doesn't ther indicated if R43 still had s, it would bother her. on 4/5/21, at 6:30 p.m., R43 common area with the ered under her chair and residents were present in the a. on 4/6/21 at 2:18 p.m., R43 or area in her wheelchair with bag under the chair and esidents were present as bingo t this time. on 4/7/21 at 7:09 a.m., R43 or room with three other wered catheter bag attached air and visible. 4/7/21, at 2:02 p.m., nursing dicated most catheter bags but this one must not have, but e the catheter bags covered. on 4/8/21, at 8:22 a.m., R43 the main dining area with oresent, down the hallway to with catheter bag under the	F 550			

Facility ID: 00038

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		AND HUMAN SERVICES				FORM	: 05/19/2021 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COM	E SURVEY IPLETED C
		245517	B. WING	i			09/2021
NAME OF	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
OAKLAV	VN CARE & REHABIL	ITATION CENTER			201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550 F 657 SS=D	rooms the catheter added that some ca cover and others do didn't. During interview on director of nursing of should be covered rooms or is visible. A policy and proced catheter bags are of provided. Care Plan Timing a CFR(s): 483.21(b)(0) §483.21(b) Compre §483.21(b)(2) A con be- (i) Developed within the comprehensive (ii) Prepared by an includes but is not I (A) The attending p (B) A registered nur resident. (C) A nurse aide wi resident. (D) A member of fo (E) To the extent pr the resident and the An explanation mus medical record if th and their resident rr not practicable for t resident's care plan (F) Other appropria	bag is covered. NA-D further atheter bags come with a on't and apparently this one 4/08/21, at 11:36 a.m., the confirmed catheter bags when residents leave their dure related to ensuring covered was requested and not and Revision 2)(i)-(iii) ehensive Care Plans mprehensive care plan must n 7 days after completion of assessment. interdisciplinary team, that imited to shysician. rse with responsibility for the th responsibility for the th responsibility for the od and nutrition services staff. acticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined the development of the	F				5/14/21

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		AND HUMAN SERVICES			PRINTED: 05/19 FORM APPRO OMB NO. 0938-	OVE
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED C	
		245517	B. WING _		04/09/202	21
	PROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPL	ÉTIO
F 657	team after each as comprehensive and assessments. This REQUIREMEN by: Based on observat review the facility far related to denture un reviewed for activiti Findings include: R5's annual Minimu assessment dated issues. The MDS f severe cognitive im R5's care plan print resident had full up bottom had some in noted. R5's care sheet util (NA) dated 4/7/21, upper dentures and On 4/6/21, at 2:52 p in a wheelchair in h at that time and corr opened her mouth were present. Res though stated she un remaining bottom to When interviewed of assistant (NA)-F sta	the resident. evised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced tion, interview and document ailed to revise the plan of care use for 1 of 4 residents (R5) ies of daily living (ADLs). um Data Set (MDS) 7/1/20, indicated no oral/dental further indicated R5 had apairment. ted 4/8/21, indicated the per dentures and on the nissing teeth with no problems lized by the nursing assistants indicated the resident had d a lower partial. p.m. R5 was observed seated her room. R5 was interviewed nfirmed being edentulous and to further confirm no teeth ident denied wearing dentures used to prior to having her	F 65	Affected resident's (R5) care plan revised to reflect the resident's cu- preferences related to denture us All residents were reviewed for ac documentation in the care plan re- oral cares and denture use and completed, if needed. All licensed staff were educated of importance of timely care plan re- and updating resident preference needed. Director of Nursing or designee w conduct random audits to ensure care plan revision related to resid preference for denture use. Audit completed weekly x4, monthly x2 report to QA for further review and recommendations.	arrent e. courate elated to on the vision s, as vill timely ent s will be and	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245517	B. WING _				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	/N CARE & REHABIL	ITATION CENTER		-			
				IVIA	NKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	ever wearing dentu When interviewed of confirmed R5 used something done to hadn't worn them for medicine cabinet in to locate the dentur When interviewed of manager licensed p being unaware if R5 further stated the in and NA care sheet updated. LPN-A sta LPN-B regarding R5 When interviewed of stated she had follo LPN-B related to R5 R5 used to have a l oral surgeon severa existing bottom teet to be refitted with a refusing to wear he confirmed staff had room in her purse. wanted to wear it sf was removed from	ad not witnessed the resident res. on 4/8/21, at 1:32 p.m. NA-E to wear dentures but had her mouth making it sore so or awhile. NA-E searched R5's the bathroom but was unable es. on 4/8/21, at 1:40 p.m. nurse practical nurse (LPN)-A stated 5 had dentures or not and formation on the care plan may be old and need to be ated she would follow-up with	F 65	57			
F 658 SS=D	indicated the care p updated as the con- resident changes.	are Planning, revised 6/2019, blan is to be modified and dition and care needs of the Meet Professional Standards	F 65	58			5/14/21

		AND HUMAN SERVICES			F	FORM	05/19/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (>		E SURVEY PLETED
		245517	B. WING				,)9/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 01 OAKLAWN AVENUE		
OAKLAW	/N CARE & REHABIL	ITATION CENTER			IANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From pa CFR(s): 483.21(b)(3)(i)	F6	658			
	The services provic as outlined by the c must- (i) Meet professiona This REQUIREMEN by: Based on observat review the facility fa cream by trained or residents (R34, R4 administration. Findings include: R34's current physi cream (a prescription treatment of various unit/GM (units per g topically two times a R34's care plan prin alteration of skin into breakdown. Interve skin breakdown for and to document or (medical doctor) or assistant-certified) On 4/7/21, at 10:50 (LPN)-A was observe medications to be a tube (g-tube). LPN off R34's creams th had applied, in the administration reco	prehensive Care Plans ded or arranged by the facility, comprehensive care plan, al standards of quality. NT is not met as evidenced tion, interview and document ailed to administer prescription r licensed staff for 2 of 6 1) observed during medication cian orders included: Nystatin on medicine approved for the s fungal infections) 100,000 gram). Apply to skin creases a day for skin integrity. Inted 4/7/21, indicated an tegrity with risk of skin entions included to monitor signs/symptoms of infection in skin conditions and keep MD PA-C (physician informed of changes. a.m. licensed practical nurse ved setting up R34's administered via gastrostomy -A stated she first had to sign hat the nursing assistant (NA) electronic treatment rd (eTAR). LPN-A stated they nce creams and that was why			Affected residents (R34 and R41) wi have prescription creams administered trained or licensed staff. All residents receiving prescription cre have the potential to be affected; all residents receiving prescription crear will have them administered by trained licensed staff. All licensed staff were educated on p administration of prescription creams trained or licensed staff. Director of Nursing or designee will conduct random audits to ensure pro administration of prescription cream trained or licensed staff. Audits will be completed weekly x4, monthly x2 and report to QA for further review and recommendations.	ed by reams ms ed or proper s by oper by e	

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		AND HUMAN SERVICES				FORM	APPROVED
	CONTRACT	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIP			0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			à		PLETED
		245517	B. WING				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER		l	5	STREET ADDRESS, CITY, STATE, ZIP CODE		05/2021
	/N CARE & REHABIL	ITATION CENTER		:	201 OAKLAWN AVENUE		
UARLAN				I	MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 658	Continued From pa	-	F 6	658	3		
	the NA's were able	to administer them.					
	confirmed she had to R34's extremities obtained them from (TMA). NA-I was u creams and powde On 4/8/21, at 8:54 a delivering 4 differen individual medicatio written the name of labeled Nystatin. N room completing m creams on the beds NA's where the crea- body. TMA-A then like her "cheat shee cream was to be ap TMA-A left the shee exited the room. N TMA-A exited R34's	on 4/7/21, at 2:29 p.m. NA-I applied creams and powders and groin that morning and the trained medication aide nsure what the names of the rs were. a.m. TMA-A was observed at creams to R34's room in on cups. On each cup was the cream; one cup was A-E and NA-F were in R34's orning cares. TMA-A set the side table and instructed the am was to be applied on R34's asked the NA's if they would et" which indicated where each oplied and they indicated yes. et on R34's bedside table then A-E was interviewed after s room and confirmed when cares for R34, the NA's were					
	expected to apply the TMA or the nurse R41's current physicincluded: Treatmer (reddened skin) rase thigh and diffuse er left posterior thigh in area with mild soap completely. Apply of	ne creams brought to them by					
	On 4/8/21 at 9:24 a setting up a single of	.m. TMA-A was observed dose of clotrimazole cream for lso going to apply a condom					

Facility ID: 00038

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		AND HUMAN SERVICES				FORM	: 05/19/2021 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED C	
		245517	B. WING				09/2021	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
OAKLAV	VN CARE & REHABIL	ITATION CENTER			01 OAKLAWN AVENUE JANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 658 F 676 SS=D	room with the need was already in R41 cares. R41 was ob scrotum and inner to instructed NA-F to a to the rash on R41's so TMA-A wouldn't prior to applying R4 then applied the ph R41. When interviewed of confirmed NAs wer creams for preventi were given only a s and were directed of cream. If the reside monitoring then the applying it. When a cream such as Nys confirmed those we would need to cheo (DON) to see what When interviewed of DON confirmed NA prescription creams A policy on medicat requested but not re Activities Daily Livin CFR(s): 483.24(a) Based of assessment of a re resident's needs an	ident. TMA-A entered R41's ed cream and supplies; NA-F 's room providing morning served to have a reddened high on the left side. TMA-A apply the clotriamazole cream s left scrotum/inner thigh area need to change her gloves 1's condom catheter. TMA-A ysician ordered cream for on 4/8/21, at 1:40 p.m. LPN-A e allowed to administer ion of skin breakdown as they ingle dose in a medication cup exactly where to apply the ent had an area they were nurse or TMA should be asked if that would include a tatin or clotrimazole, LPN-A ere prescription creams and sk with the director of nursing her expectations would be. on 4/9/21, at 11:24 a.m. the 's were not to be applying s for residents. tion administration was eccived. ng (ADLs)/Mntn Abilities	F 6				5/14/21	

Facility ID: 00038

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	05/19/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	245517	B. WING) 9/2021
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAWN CARE & REHABIL	ITATION CENTER		_	01 OAKLAWN AVENUE IANKATO, MN 56001		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
 daily living do not di of the individual's cl that such diminution includes the facility §483.24(a)(1) A rest treatment and servit or her ability to carr living, including those of this section §483.24(b) Activitie The facility must pro- accordance with pa activities of daily livies §483.24(b)(1) Hygies grooming, and oral §483.24(b)(2) Mobilincluding walking, §483.24(b)(2) Mobilincluding walking, §483.24(b)(3) Elimities §483.24(b)(3) Elimities §483.24(b)(4) Dininant snacks, §483.24(b)(5) Com (i) Speech, (ii) Language, (iii) Other functionant This REQUIREMENt by: Based on observations activity facility facompleted for 1 of the states 	ent's abilities in activities of iminish unless circumstances linical condition demonstrate n was unavoidable. This ensuring that: sident is given the appropriate ices to maintain or improve his y out the activities of daily se specified in paragraph (b) so of daily living. ovide care and services in tragraph (a) for the following ing: ene -bathing, dressing, care, lity-transfer and ambulation, nation-toileting, ng-eating, including meals and munication, including I communication systems. NT is not met as evidenced tion, interview, and document ailed to ensure nail care was 1 resident (R5) who required oming, and were reviewed for	F	576	Affected resident (R5) had nail care completed. All residents were assessed for nail and completion of nail trimming. NA sheets and resident care plans were	care R Hall	

Facility ID: 00038

	OF DEFICIENCIES OF CORRECTION	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT COM	0938-039 E SURVEY PLETED
		245517	B. WING _			C 09/2021
	PROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, 201 OAKLAWN AVENUE MANKATO, MN 56001	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 676	Continued From pa	age 11	F 67	6		
	Finding include:			reviewed and updated, All-staff educated on en	suring all personal	
	assessment dated	mum Data Set (MDS) 12/29/20, indicated R5 had cognition and required limited rsonal hygiene.		grooming needs were met, per re plan of care. Director of Nursing or designee w conduct random audits to ensure completion of personal grooming. will be completed weekly x4, mon	esignee will to ensure grooming. Audits	
		ted 4/8/21, directed staff to nd trim and clean on bath day		will be completed week and report to QA for fur recommendations		
		ekly Skin Inspections indicated d her nails trimmed on 3/9/21.				
	in a wheelchair in h long fingernails with on the ends. R5 w was. R5 looked at "This one needs to	p.m. R5 was observed seated her room. R5 had extremely h some of them being jagged as unaware when her bath day her right thumbnail and stated, be trimmed". The thumbnail d a v-shape out of part of the				
		p.m., 4/7/21, at 10:10 a.m. and . R5 was observed with long,				
	medication aide (T routinely receive na as needed. TMA-A confirmed they wer further confirmed F	on 4/8/21, at 1:21 p.m. trained MA)-A stated residents ail care on their bath day and A observed R5's fingernails and re long and jagged. TMA-A R5's bath day was on Tuesday or) and nail care should have that time.				

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		AND HUMAN SERVICES & MEDICAID SERVICES		FC	ED: 05/19/2021 RM APPROVED NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED		
		245517	B. WING		C 04/09/2021		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
OAKLAV	/N CARE & REHABIL	ITATION CENTER	201 OAKLAWN AVENUE MANKATO, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 676 F 677 SS=D	completed on their refuse their bath, the reapproached for co The policy titled, Ba February 2018, did care at the time of a ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A res out activities of daily services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility fa timely toileting and provided for 3 of 3 of reviewed for activiti were dependent up Findings include: R34's admission Mi assessment dated a having severely implextensive staff assis that included groom R34's current care p R34 as requiring as hygiene that included assistance due to s	for residents should be bath day. Should the resident ley should still be ompletion. ath, Shower/Tub, revised not address providing nail a bath or shower. for Dependent Residents 2) ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview, and document ailed to ensure grooming, incontinence cares were (R34, R41, R43) residents es of daily living (ADLs), who on staff for care.	F 676		nd ff g ved or y will		

Facility ID: 00038

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		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED C
		245517	B. WING				09/2021
	PROVIDER OR SUPPLIER	ITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 01 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	Review of the nurs dated 4/6/21, direct ADL's During observation was observed to ha chin and upper lip. During observation 2:30 p.m. R34 was facial hairs on the of confirmed he was mustache and wou During observation continued to have l upper lip. During interview or assistant NA-A and on bath days which Thursdays. NA-A a facial chin and upp should have been s indicated R34 was and required daily s During interview or confirmed R34 req shaving and should During interview or practical nurse (LP daily assistance wi indicated the NA's and shaven when r	on 4/5/21, at 2:00 p.m. R34 ave long facial hairs on the and interview on 4/6/21, at observed again to have long chin and upper lip. R34 not growing a beard or ld like to be shaved. on 4/7/21, at 8:30 a.m R34 ong facial hair on the chin and 4/7/21, at 9:00 a.m. nursing I NA-B indicated R34 is shaved of son Mondays and nd NA-B confirmed R32's er lip hairs were long and shaved. NA-A and NA-B further unable to shave independently staff assistance. a 4/7/21, at 9:00 a.m. NA-C uired staff assistance with d be shaved daily if needed. a 4/8/21, at 10:00 a.m. licensed N)-A confirmed R34 requires th ADL's. LPN-A further should be checking R34 daily,	F 6	577			

Facility ID: 00038

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		AND HUMAN SERVICES				FORM	APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES			חוד			0938-0391 E SURVEY
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
			_			(C
		245517	B. WING			04/0	09/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	/N CARE & REHABIL	ITATION CENTER	201 OAKLAWN AVENUE MANKATO, MN 56001				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
			ı		DEFICIENCY)		
F 677	Continued From pa	ao 14	F 6	277	,		
1 0//	upper lip.	ge 14	FC)//			
	R41						
	R41's diagnosis rer	port printed on 4/9/21,					
		s of Alzheimer's disease,					
	Parkinson's disease disease, and weakr	e, diabetes, chronic kidney ness.					
		imum Data Set (MDS) 3/18/21, indicated R41 had					
		impairment, adequate vision					
	and hearing, clear s	speech, understood others and					
		imself understood. R41 was					
		aff for bed mobility, transfers, Init, dressing, toileting and					
		, R41 had an external urinary					
		requently incontinent of bowel.					
	R41's plan of care	last reviewed on 4/6/21,					
	indicated R41 had f	requent bowel incontinence					
		ked every two hours and as					
1	needed. R41 also h	ad an alteration in elimination,					

If continuation sheet Page 15 of 53

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	. 0938-039 E SURVEY
		245517	B. WING		04	C
NAME OF	PROVIDER OR SUPPLIER	240317		STREET ADDRESS, CITY, STATE, ZIP CODE	04	/09/2021
OAKLAV	VN CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 677	be toileted every tw had an alteration in were to keep his sk dry. R41's order summa indicated an order f each morning and a During document re task sheet dated 4// toileted every two h a condom catheter During document re 3/4/21, indicated R4 several weeks and to attempt to keep t incontinent of urine pink area left media darker edges. Scro- erythematous (red s candida (yeast infect inflammation, usual as the groin or betw During document re (NP) note dated 3/8 and redness to left of prior week, the N that R41's rash was cause of rash contin fecal incontinence. recommended to he	Ary report printed on 4/9/21, for a condom catheter; replace as needed. Ary report printed on 4/9/21, for a condom catheter; replace as needed. Ary report printed on 4/9/21, for a condom catheter; replace as needed. Ary report printed on 4/9/21, for a condom catheter; replace as needed. Ary report printed on 4/9/21, for a condom catheter; replace as needed. Ary report printed on 4/9/21, for a condom catheter; replace as needed. Ary report printed R41 was to be ours and prn, and was to wear in bed. Ary report printed R41 was to be ours and prn, and was to wear in bed. Ary report printed R41 was to be ours and prn, and was to wear in bed. Ary report printed R41 was to be ours and stool. Skin: large pale al thigh with slightly raised tum with irregular-shaped skin) rashes consistent with ction). Intertrigo (skin and stool. Skin: large pale al thigh with slightly raised tum with irregular-shaped skin) rashes consistent with ction). Intertrigo (skin and stool. Skin: large pale al thigh and groin. In the middle IP had been notified by staff is not improving; the probable nued to be his urinary and A condom catheter trial was elp manage R41's urinary ollowing day, staff reported the		7		

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 05/19/2021 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245517	B. WING			C 09/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	while R41 was in th of urine was noted of bottom fitted sheet measuring approxim The incontinence parapproximately 12 in Daily Care Sheets f resided indicated the were checked, char were hand-written of was no correspondie who toileted resider On 4/6/21, the sheet 2:00 p.m. However observation from in hallway outside of F 3:48 p.m., no staff of him. It wasn't until s R41's room at 3:48 get toileted and char interviews on 4/6/21 1:29 p.m., R41 was closed. No one had though the foul odo outside of his room 2:37 p.m., R41 was closed. 2:51 p.m., during a outside of R41's root stated she did not of asked how she kne resident was to be n stated she had that 3:02 p.m., during a	e dining room, a strong smell on his side of the room. R41's had a round damp circle on it nately 12 inches in diameter. ad had a damp area on it also, iches in diameter. or the south wing where R41 ie date and times residents nged or toileted. The times on the sheet by NA's. There ing name or initials to indicate hts. et indicated R41 was toileted at during a continuous side R41's room, or the R41's room from 1:29 p.m. to checked on him or toileted staff were asked to go into p.m. to check his brief, did he inged. Observations and I, include: as laying in bed watching TV. , foul odor of stool. as laying in bed with eyes come into R41's room, even r was noticeable in the hallway as laying in bed with his eyes an interview in the hallway om, nursing assistant (NA)-I earry a NA task sheet. When w the frequency at which a repositioned or toileted, she	F 677	7		

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION). 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· ,			MPLETED
						С
		245517	B. WING		04/09/2021	
NAME OF F	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	N CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 677	Continued From pa	ge 17 uired repositioning or toileting	F 677	,		
	at specific intervals her pocket which in every two hours an	, (NA)-L removed a sheet from dicated R41 should be toileted				
	closed. No staff had observation started permeating the hall	d come into his room since at 1:29 p.m. despite foul odor way.				
	walked into R41's r When asked if R41	medication aid (TMA)-A oom to talk to his roommate. participated in activities, didn't get out of bed except for				
	meals. 3:44 p.m., when a last toileted at 2:00	sked, NA-L stated R41 was p.m. according to the Daily ver, this was not observed				
	during continuous of 3:48 p.m., NA-L w At R41's bedside, N					
	foul odor in room pe R41's brief, it was s	ersisted. When NA-L checked saturated with urine and stool. could be saturated with urine				
	R41 tended to pull catheter was not in	ndom catheter, NA-L stated the catheter off. Noted R41's place when NA-L pulled back R41 out of bed, into a				
	wheelchair and into sheet had been soi brief had been soile	the bathroom. R41's fitted led with urine and stool, his ed with urine and stool, as				
	over his brief, as we pants he was wear	erwear with snaps that were ere the rust colored sweat ng. R41's coccyx was reddened area about the size				
	of a hand which ap Redness was noted	peared raised and bumpy. d in his groin also. While R41 bilet, NA-L stripped the bed				

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CO	MPLETED
		245517	B. WING		04	C / 09/2021
NAME OF	PROVIDER OR SUPPLIER	240011		STREET ADDRESS, CITY, STATE, ZIP CODE		/09/2021
OAKLAV	VN CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 677	practical nurse (LPI replace R41's cond condom catheter ge moves, adding that skin and that was w catheter. After bein a clean brief and sw R41 was assisted b During an observat R41 was laying in b partially covering hi same sweatshirt fro smelled of urine. During an observat 9:20 a.m., (NA)-F a to get R41 up for br to be saturated with removed it. NA-F st had fallen off. NA-F brief had been check According to the Da been checked 8:30 prior to NA-F finding TMA-A came into F condom catheter. A applied, which was which was attachec The drainage tubing with an elastic and enough give to the it could pull the con stated "we are cons catheter because it to wash R41's groin	ge 18 s on the bed. Licensed N)-A went into the bathroom to om catheter. LPN-A stated the ets pulled off when R41 R41's urine was toxic to his /hy he wore the condom g cleaned up in the bathroom, veat pants were put on, and back into the wheelchair. ion on 4/7/21, at 7:44 a.m., red with eyes closed; sheet m; wearing just a brief and the om the day before. Room ion and interview on 4/7/21, at nd (NA)-G entered the room reakfast. Observed R41's brief hyellow urine when NA-F tated R41's condom catheter d id not know when R41's cked or changed last. aily Care Sheet, his brief had a.m. and was dry (40 minutes g it saturated with urine). R41's room and replaced his a new condom catheter was attached to drainage tubing, d to a urinary drainage bag. g was secured to R41's left leg Velcro strap. There was not tubing if the strap slid down dom catheter off. (NA)-G stantly changing his condom falls off." As NA-F continued h, it was noted to be red. NA-F etty bad; I know it's sore."				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245517	B. WING			C 09/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	/N CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	assisted into a whe bottom sheet, incor absorbent pad to be NA-F, but not chang returned from break bed with the same s During an interview 1:30 p.m., R41 was lunch by NA-F who changed once a we assisted R41 into b bedding and chang mattress was not cl asked if the condon NA-F stated it was, his pants to his che came to the room to they first started usi improved, but it was it was, but it's still n During an interview 8:22 a.m., a very st in the hallway outsid room. At 9:16 a.m., R41 up for breakfas and stated the condon at stated the condon TMA-A. Discussed short distance betw appeared to be the frequently being pul-	eft posterior thigh. As R41 was elchair for breakfast, observed thinence pad and disposable e damp, which was verified by ged. At 10:50 a.m., R41 kfast and was assisted into soiled bedding still in place. and observation on 4/7/21, at returned to his room after stated resident bed linen was tek after their bath. As NA-F ed, she noticed the soiled ed it. The bare rubber eaned prior to this. When n catheter was still in place, however when she removed ck brief, it came off. TMA-A o replace it. TMA stated when ing the catheter, his skin had s worse again"it's better than	F 677			
	frequently being pul were looking into a	lled off. TMA-A stated they different device to secure the				

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	FORM	APPROVED					
CENTERS FOR MEDICARE & MEDICAID SERVICES O STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION							0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,		ECONSTRUCTION		PLETED
			A. BOILDI	- NG	·····	(C
245517			B. WING _				09/2021
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAWN CARE & REHABILITATION CENTER			20	01 OAKLAWN AVENUE			
				М	ANKATO, MN 56001		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
			i				
F 677	Continued From pa	ge 20	F 67	77			
		on 4/8/21, at 9:58 a.m.,					
		urse (LPN)-B stated R41 was					
	able to toilet himsel	dded staff should be checking					
		three hours, checking either					
		him. LPN-B stated now that					
		catheter, it was easier to					
		asked when R41 was last					
		l at the Daily Care Sheet for 5:15 a.m., adding she would					
		to be looked at again					
		and 8:00 a.m. LPN-B was					
		t been looked at until 9:15					
		NA's likely gave R41 a longer					
		he had a condom catheter					
		looking for incontinent bowel					
		. Daily Care Sheets for ewed with LPN-B for residents					
		ere R41 resided. It was					
		B that on 4/6/21, 15 residents					
	were checked, char	nged or toileted at 2:00 p.m.					
		idents were checked, changed					
		.m., and seven residents at 11					
		our NA's on the south unit, heck, change and toilet that					
		he same time? LPN-B stated					
		kely not the exact times the					
		s NA's don't document on the					
	sheet right after the	task was performed.					
	During on charges	ion and interview on 1/0/01 -t					
		ion and interview on 4/9/21, at laying in bed. At 9:47 a.m., he					
		9:49 a.m., LPN-B was asked					
		R41's brief had been checked					
		and she replied she didn't know					
	because it was not	documented on the Daily Care					
		om was entered with LPN-B,					
	without prompting,	R41 stated "I'm being					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245517	B. WING				C 09/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	/N CARE & REHABIL	ITATION CENTER			01 OAKLAWN AVENUE IANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	breakfast yet, or if s yet and R41 replied R41's sheet, his bri sweat pants were v catheter was off ag- came into the room to have his brief che when checked on e expected staff to ph brief for someone li disease, not just as adding R41 was no his needs accurated During an interview DON stated R41 was toileted every two h DON stated R41 m to be changed, but would expect staff t DON was not award changed or toileted was her expectation care. The DON was frequency of R41's until recently, and s more secure device if staff routinely invet to determine the so saturated brief, soil DON stated R47 another residents m	sked him if he had been to staff have been into his room no. When LPN-B pulled back ef, cloth underpants and isibly wet and R41's condom ain. At 10:04 a.m., (NA)-D and stated R41 had refused ecked and refused to get up arlier. LPN-B stated she sysically check a residents ke R41 who had Alzheimer's k if he needed to be changed, t always able to communicate	F 6	77			

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	MENT OF HEALTH		FORM	APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		(X3) DATE	E SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	A. BUILDING			COMPLETED		
		245517	B. WING _				09/2021	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
OAKLAW	/N CARE & REHABIL	ITATION CENTER			11 OAKLAWN AVENUE ANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 677	Continued From pa	ge 22	F 67	77				
	R43							
	assessment dated a severe cognitive im rarely understood a	num Data Set (MDS) 3/18/21, indicated R43 had pairment, does not speak, is nd rarely understands, assist of two for bed mobility, onal hygiene.						
	totally dependent or additional care plan alteration in elimina included a toileting	ed 3/28/21, indicated R43 was n staff for toilet use. An dated 7/17/18, indicated an tion related to Alzheimer's and plan for checking and hours and as needed.						
	5:34 p.m., family measked them to allow meals and to wake meals and to check so she is awake be	and interview on 4/5/21, at ember (FM) indicated he has v R43 to rest in bed after R43 about an hour before and change her as needed fore he comes to assist her to lo it and stated "I guess it is st is."						
	7:30 a.m., R43 brou room from the dinin the television. 8:00 a.m., R43 dozi change. No staff a	y observed on 4/7/21: ught out to the common sitting g room and placed in front of ng in chair without position oproached R43. ains in common sitting room,						

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		AND HUMAN SERVICES				FORM	: 05/19/2021 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY IPLETED C
		245517	B. WING				09/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
OAKLAW	/N CARE & REHABIL	ITATION CENTER			201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	Continued From pa	ae 23	F 6	677	7		
		No staff have approached					
	8:50 a.m., R43 ren	nains sitting in common room No staff have approached					
	9:15 a.m., R43 ren	nains in common room dozing No staff have approached					
	9:45 a.m., R43 ren	nains in common room, no nd no staff have approached					
		mains in common room, no nd no staff have approached					
	room and no staff h	mains sitting in the common have approached R43. mains in common room, no					
		nd no staff have approached					
	11:15 a.m., R43 re	mains in common room, no nd no staff have approached					
	11:54 a.m., R43 rer position changes a	nains in common room, no nd no staff have approached					
		nily member arrived and R43 g room. Staff assisted resident did not toilet her.					
	12:55 p.m., R43 rer family member.	mains in dining room with moved back to the common					
	room, remained se	ated in her wheelchair, was ced in front of the television					
	1:38 p.m., R43 rem repositioning or toil	ains in the common room, no					
	spoke to R43 and t	hen requested staff lay her R43 appeared tired.					

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	FORM	APPROVED 0938-0391					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION							E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDIN	NG _			PLETED C
		245517	B. WING _				09/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
OAKLAW	N CARE & REHABIL	ITATION CENTER		-	01 OAKLAWN AVENUE ANKATO, MN 56001		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 24	F 67	77			
	member (FM) indica put back in her bed she isn't so tired wh eat, but they don't li indicated it is easier chair and sit her our station (common ar is concerned they d FM indicated he has times about this iss doesn't get done.	4/7/21, at 1:22 p.m., a family ated he has requested R43 be in the morning for awhile so hen he comes to assist her to sten to me. FM further r for them to leave her in her t in the area by the nurses rea) to keep an eye on her but lon't reposition or toilet her. s spoken to the facility many ue and is very frustrated that it and interview on 4/7/21, at					
	2:02 p.m., nursing a wheeled R43 to her lift transferred R43 incontinent pad. F stool in incontinent around the edges. R43 was last toilete and would have to o	assistant (NA)-A and NA-B, room and using mechanical to her bed and checked R43 had a large brown formed pad with stool dried to the skin NA-A was questioned when ed indicated she was unsure check. Skin was red after n 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.						
	indicated they try to and check her pad, if they are short sta aware the family me down between mea						
	During interview on	4/08/21, 11:36 a.m., the					

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		AND HUMAN SERVICES			FORM	: 05/19/202 APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X			IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		245517	B. WING _			C / 09/2021
	PROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE
F 677	expect staff to follo states every two ho change the residen The facility policy ti (ADLs), Supporting indicated: 1. Residents who activities of daily liv the services necess grooming and pers 2. Appropriate can provided for residen ADLs independentil accordance with the support and assista 3. If residents with dementia resist can the underlying caus assume the residen Approaching the re different time, or ha speak with the residen Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pr practice, the comprise care plan, and the	(DON) confirmed she would w the plan of care and if it purs, they should check and it every two hours. tled Activities of Daily Living , with revised date of 3/2018, are unable to carry out ing independently will receive sary to maintain good nutrition, onal and oral hygiene. re and services will be nts who are unable to carry out y, with consent and in e plan of care, including ance with elimination (toileting). n cognitive impairment or re, staff will attempt to identify se of the problem and not just nt is refusing or declining care. sident in a different way or at a aving another staff member dent may be appropriate. care fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered	F 67			5/14/21

Facility ID: 00038

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		& MEDICAID SERVICES	1		MB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY PLETED
			A. BUILDIN	la		C
		245517	B. WING			_ 09/2021
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
OAKLAW	/N CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 684	review, the facility facility facility	tion, interview and document ailed to comprehensively	F 68	Affected resident s (R20) orders treatments were reviewed and upo	dated.	
	for 1 of 1 resident (e ongoing treatment for edema R20), who required leg wraps event and treat edema.		R20's orders and care plan were r and updated. R20 was assessed a treated for edema, per plan of car All residents were reviewed for co	and e.	
F				of assessment and treatment of e needed. Care plans and hall shee reviewed for like-identified residen	ts were	
	R20's Face Sheet printed 4/8/2 diagnosis's of acute heart failur doesn't pump enough blood to demand), peripheral vascular d circulation disorder that causes heart and brain to narrow, block 2 diabetes mellitus, chronic kidu 3 (moderate kidney damage), a of left leg below the knee and n	gh blood to meet body's al vascular disease (a that causes blood outside of narrow, block, or spasm), type , chronic kidney disease stage damage), acquired absence		updated, as needed. All-staff educated regarding timely assessment and treatment of ede Director of Nursing or designee wi conduct random audits to ensure assessment and treatment of ede all residents, if required. Audits wi completed weekly x4, monthly x2 report to QA for further review and	ma. II timely ma for II be and	
	assessment dated a cognition with impa	imum Data Set (MDS) 2/5/21, included intact irment of range of motion on xtremity with limb prosthesis.		recommendations.		
	compression to righ boot, moisturize leg assessing for any a provider if any skin immobilizer to right figure 8, direction fr resident to elevate	ers dated 9/22/20, included nt leg in a.m.: Remove Rooke g with moisturizer in his room alteration in skin integrity, notify problems occur. Apply knee knee. Apply ACE wrap in rom toes to knees. Encourage legs as much as possible. A d 12/29/20, included encourage legs every shift.				
	alteration in skin int immobility post hos below the knee am	dated 10/15/20 included an tegrity related to weakness and pitalization related to left putation. Intervention included extremity, encourage				

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	ND HUMAN SERVICES			FORM	APPROVED
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES (X1)	MEDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA				0938-0391
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
				(2
	245517	B. WING _		04/0	09/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAWN CARE & REHABILITAT	TION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
deficit related to weakn the knee amputation w assist of one with perso During observation and 12:44 p.m., R20 was si his room with right leg floor, no ace wrap press present. Skin was red leg was dependant also amputation present wit indicated he has a lot of and he is supposed to in the morning when th (vascular boot to nature doesn't happen every of generally has to ask th of the staff don't know them on it when I have medical field." R20 ind helps the swelling in hi the staff do not have tir his legs up as they are During observation on was asleep in his chair ace wrap present on rig During interview on 4/6 indicated he has not el When asked if staff rer they don't have time fo During interview and of 7:11 a.m. R20 was in re dependant with right fo	remities as much as also included a self-care mess related to left below with intervention including sonal hygiene and dressing. Ind interview on 4/5/21, at sitting in a recliner chair in dependant and foot on the sent and lower leg edema d from mid-calf to foot. Left so and a below the knee ith no prosthesis on. R20 of swelling in his right foot o have his right leg wrapped hey remove his Rooke boot rally warm the limb) but it day. R20 indicated he nem to do it and then "half y how to do do I educate e zero education in the ndicated the ace wrap really his feet. R20 further stated ime to remind him to keep e too busy for that. 10 4/6/21, at 9:29 a.m., R20 fir with legs dependant and right lower leg. 16/21, at 2:26 p.m., R20 elevated his legs today. emind him he indicated no or that.	F 68			

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		AND HUMAN SERVICES			FORM	05/19/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY PLETED
		245517	B. WING			C 09/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE		
OAKLAV	WN CARE & REHABIL	ITATION CENTER		MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Rooke boot remain wrap was present of NA-G put on his wrap prosthesis. R20 state to come back in 10 R20 stated some of what they are doing During interview on indicated R20 can g elevate his legs so indicated she hasn' will get another aide During interview an a.m., NA-F indicate ask him to elevate l anymore. NA-F fur the mornings and the take that off. During interview on licensed practical n care coordinator, in elevating his legs a prompt him to put h During interview on director of nursing (expect staff to remit throughout the shift on in the mornings she does she a lot of elevating his legs b reminding him.	ed on R20's right leg and ace on R20's bed. R20 requested ap and NA-G grabbed his ated "not that" and asked her minutes and wrap his leg. f these staff just don't know g. 4/7/21, at 7:22 a.m., NA-G get upset when you ask him to I don't ask him to do it. NA-G 't wrapped his leg before and e to assist with him with that. d observation on 4/7/21, 9:31 ed R20 gets upset when you his legs, so I don't do it ther stated he has a boot on in hen we wrap his leg when we A/8/21, at 10:50 a.m., hurse (LPN)-B, who is also the dicated R20 should be and she would expect staff to his legs up throughout the shift. A/8/21, 11:33 a.m., the (DON) indicated she would and R20 to raise his legs t and to have his ace wrap put per orders. The DON did add of refusals documented for but was not aware staff are not	F 684			

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		AND HUMAN SERVICES		F	TED: 05/19/2021 ORM APPROVED NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	B) DATE SURVEY COMPLETED
		245517	B. WING		C 04/09/2021
NAME OF	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
OAKLAV	/N CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION COMPLETION DATE
F 686	Continued From pa	ge 29	F 686		
F 686 SS=G		Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 686		4/12/21
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review, the facility f implement pressure of 1 resident (R84) pressure ulcer with development. The f R84 sustaining hand developed an unsta- left heel. Findings include: Pressure ulcer stag National Pressure U Unstageable Press full-thickness skin a skin and tissue loss damage within the because it is obscu	sure ulcers. orehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and oressure ulcers receives and services, consistent andards of practice, to revent infection and prevent		Affected resident (R84) was seen by Mankato Clinic wound nurse practition on 04/12/21, new orders placed for da inspection of wounds, repositioning at least every two hours when in bed/cha prevent pressure to bony prominences and to limit chair sitting to two hours. Resident R84 continues to have Week Pressure Wound Evaluations complet and continues to be seen by Mankato Clinic wound nurse practitioner bi-wee All residents were assessed who curre have identified pressure wounds for appropriate interventions and care pla and physicians updated, as needed. All licensed nursing staff were educate on how to ensure proper assessment, monitoring, and implementation of pressure reliving interventions for residents with identified pressure	iily air to s, kly ed ekly. ently ns ed

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		C
		245517	B. WING _			09/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 686		-	F 68			
	(i.e. dry, adherent, i fluctuate) on the he softened or remove R84 was admitted t diagnoses identified including: diabetes ulcer on the sacrum calorie malnutrition. During observation 5:00 p.m. R84 was eating. R84 was no boot on the left foot R84's right heel was pedal of the wheeld on his left heel, but heel. R84 confirmed protective device on stated he had freque	o the facility on 8/4/20, with d on the diagnosis report sheet mellitus, stage 4 pressure n, kidney failure and protein		concerns. Licensed nursing staf also educated on the new proce communicating skin concerns ic on admission skin assessment, any new skin concerns noted or skin assessments to the on-call manager and Director of Nursin Director of Nursing or designee conduct random audits to ensur assessment, monitoring, and implementation of pressure relie interventions for residents with s integrity issues. Audits will be co weekly x4, monthly x2 and repo for further review and recomme	ss for lentified as well as weekly nurse g. will e proper eving skin ompleted rt to QA	
	dated 8/4/20, identi extensive assistant speech, able to und understood, with go admission skin assi therefore not identifi condition. Review of a weekly 8/7/20, identified R8 pressure ulcer on th identified as measu	ssion Data Collection sheet fied R84 as requiring the with mobility, having clear derstand and able to be bod memory recall. The essment was left "blank" tying R84's current skin wound evaluation dated 84 as having a stage 4 he coccyx. The ulcer was uring 2.5 centimeters (cm) in dth, and 2.5 cm in depth. The				

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						FORM	APPROVED
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 245517 NAME OF PROVIDER OR SUPPLIER OAKLAWN CARE & REHABILITATION CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 31 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 relistribution cushion on wheelchair, pressure relistribution 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. 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<		(X 2) MU	тірі		1	0938-0391 E SURVEY	
							PLETED
						(С
		245517	B. WING			04/	09/2021
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	N CARE & REHABIL	ITATION CENTER			201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
			PREFIZ TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 686	Continued From pa	ge 31	F 6	86			
	•	-	_				
		-					
	No other description	n of the heels was					
	were implemented						
	heels.						
		itional interventions identified					
	to prevent breakdow						
	Review of a weekly	wound evaluation dated					
	9/25/20, identified a	a suspected deep tissue injury					
		asurements were 3.4 cm in dth and 0.0 cm in depth. The					
		as being purplish red in color					

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	05/19/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				0	(X3) DATI COM	E SURVEY PLETED
		245517	B. WING _					C 09/2021
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE	, ZIP CODE		
OAKLAV	VN CARE & REHABIL	ITATION CENTER		-	1 OAKLAWN AVENUE ANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE)	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 686	and skin being soft implemented includ boots on at all times Although R84 was f "boggy" heels 8/24/ implemented until th Review of a weekly 10/12/20, identified and worsening. The heels and feet were footboard of the bea left heel was descri loss, discolored skii drainage. Measuren cm length by 4.5 cm the wound was ider Review of R84's ad (MDS) assessment as having a baselin (BIMS) score of "15 The MDS identified assistance with bec indicated R84 as at indicated R84 had a ulcer. Interventions mattress, chair cus program and press Review of R84's qu dated 2/2/21, identi score of "15." The requiring extensive and positioning, ind pressure ulcers, an stage 4 pressure ul pressure ulcer. (The	and "boggy". Interventions led: pressure redistribution is and air mattress on bed. irst identified as having 20, no new interventions were his evaluation 9/25/20. wound evaluation dated R84's left heel as blistering e evaluation indicated R84's e pressing against the d. The pressure ulcer to the bed as having partial tissue n and scant serosanguinous ments were identified as 5.0 n width and 0.0 cm depth, and ntified as unstageable. mission Minimum Data Set dated 8/7/20, identified R84 e interview for mental status " (no cognitive impairment). R84 as requiring extensive I mobility and positioning, risk for pressure ulcers, and a current stage 4 pressure included: pressure reducing hion, turn and repositioning	F 68	36				

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	-	AND HUMAN SERVICES			FORM	: 05/19/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245517	B. WING			C 1 09/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	VN CARE & REHABIL	ITATION CENTER		01 OAKLAWN AVENUE JANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	Interventions includ cushion, turn and re- treatment dressing. Review of the admi 8/7/20, identified R8 risk for pressure uld identified R84 as ha on the sacrum. In a require extensive at of daily living) that i of bed. Intervention and repositioning p in chair, air mattres and a protein suppl Review of the R84's 8/26/20, identified F breakdown related mobility and current Interventions were skin integrity weekly hrs (hours) and as redistribution cushic wound measureme care. Review of the current identified R84 as ha related to pressure heel. Interventions if a donut cushion at assessments, moni- reposition every 2 h cushion to chair, ain- to accept cares, du	ded: air mattress, chair epositioning program and ission Braden scale dated 84 as having mild to moderate cers. The assessment aving a stage 4 pressure ulcer addition, R84 was identified to ssistance with ADL's (activities included lifting legs in and out is identified included: turning rogram, redistribution cushion as, weekly wound assessments lement twice daily. s admission care plan dated R84 as being at risk for skin to acute kidney failure, limited	F 686			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245517	B. WING				C 09/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	/N CARE & REHABIL	ITATION CENTER			201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	remind the resident chair no more than heel donut to the lei no preventative me heel. Review of the currer 4/8/21, included ski These orders include and pressure relief are not rested on the audits, wound care to coccyx and wour load at all times. During observation 4:00 p.m., R84 was the facility with a sta wheelchair with bott pedals. R84 was ob both feet but did no on either feet. R84 were needed when During observation 11:00 a.m., R84's lei measured by licenss The left heel ulcer r 0.0 cm. The area w covered with 80% e granulation. There we the previous week, improved. During the bed and noted to ha under the left heel, redistribution device right heel was restin	ge 34 _s, reposition every 2 hours/ to reposition, may be up in 2 hours at a time and blue ft heel at all times. There were asures identified for the right nt physicians orders dated n /pressure ulcer orders. ded: ensure heels are floated boots are in place. ensure feet te foot board, weekly skin every 3 days and as needed nd care to left heel daily and off and interview on 4/6/21 at observed to be sitting outside aff person. R84 was in the h feet resting on the foot oserved to have thick socks on t have a redistribution device stated he was not sure if they he was up in his chair. and interview on 4/8/21 at eff heel pressure ulcer was ed practical nurse (LPN)-A. neasured 5.6 cm by 5.0 cm by as identified by LPN-A to be eschar, 10% slough and 10% was an increase in depth from but the width and length had his time, R84 was resting in ave a blue heel doughnut but did not have any kind of e under the right heel. The ng on the bed. The surveyor eck the resident's right heel	F	586			

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		AND HUMAN SERVICES			FORM	: 05/19/2021 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245517	B. WING			C 109/2021
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN CARE & REHABIL	ITATION CENTER		01 OAKLAWN AVENUE JANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	that was covered w the right heel as so hardened skin arou measured a 1/4 inc blanchable. There w R84 stated he was Interview with LPN- did not have any or redistribution device there had been no p LPN-A stated the w responsible to mon During interview on and NA-B indicated of the time, but staf occasionally. NA-A to have a blue heel times when in bed. R84 did not have and device for the right R84 utilizes the blue verified staff are no donut properly whe During interview wit p.m. RN-A confirmed a pressure redistrib even though R84 w RN-A confirmed R8 assessment identifii interventions imple breakdown. RN-A v identified with "bogg unstageable pressu weeks later.	 ith a sock. LPN-A described ft, slightly pink in color, with and the edges. The center area and the edges of the area. A at this time, confirmed R84 ders for a pressure eto R84's right heel and that previous redness in the area. Yound nurse is currently itor R84's skin. 4/7/21, at 9:30 a.m. NA-A and NA-B confirmed R84 was donut to his left heel at all NA-A and NA-B also verified ny kind of pressure reduction heel. NA-A and NA-B stated e heel donut when in bed, but always able to place the n R84 is up in the wheelchair. th RN-A on 4/8/21, at 1:00 and R84 did not have orders for but on device to the right heel, was at risk for pressure ulcers. 	F 686			

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		AND HUMAN SERVICES				FORM	: 05/19/2021 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY IPLETED C
		245517	B. WING				09/2021
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	•	
OAKLAV	VN CARE & REHABIL	ITATION CENTER			I OAKLAWN AVENUE ANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686 F 688 SS=D	DON confirmed R8 assessment comple DON also verified F breakdown. The DO were identified to be have been implement she would expect s skin on admission i interventions neede The facility's 7/18 p Wound Manageme pressure wound ev is identified, notify t provider. Provide in identification of pre associated risk fact Increase/Prevent D CFR(s): 483.25(c)(§483.25(c)(1) The f resident who enters range of motion do range of motion un condition demonstr of motion is unavoid §483.25(c)(2) A res motion receives ap services to increase prevent further dec §483.25(c)(3) A res receives appropriat assistance to maint the maximum pract	4 was admitted without a skin eted until 3 days later. The R84 was at risk for skin DN stated when R84's heels e "boggy" interventions should ented. The DON further stated taff to assess the resident's n order to determine ed to prevent skin breakdown. olicy Skin Assessment and nt, included: Initiate a weekly aluation when a pressure ulcer he wound nurse and update iformation regarding clinical ssure ulcers/injuries and tors. eccrease in ROM/Mobility 1)-(3) facility must ensure that a s the facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range	F 6				5/14/21

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		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245517	B. WING) 09/2021
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN CARE & REHABIL	ITATION CENTER			01 OAKLAWN AVENUE ANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	This REQUIREMEI by: Based on observative review, the facility for restore, maintain and motion (ROM) for 3 R21), reviewed for mobility. Findings include: R8 was admitted to diagnosis (identified in the medical reco- cerebral vascular and polyneuropathy (mothroughout the bod osteoarthritis (arthroughout the	NT is not met as evidenced tion, interview and document ailed to provide services to ad prevent loss of range of of 3 residents (R8, R2 and range of motion (ROM) and the facility on 2/16, with d on the diagnosis report sheet rd) dated 4/9/21, that included: ccident (CVA) (stroke) alfunction of peripheral nerves y) chronic kidney disease, itis in the joints) and fracture of rvation on 4/7/21, at 9:00 a.m. itting in a wheelchair in the /. R8's left hand was noted to sting on his lap. When asked s right hand he was only able R8's 2nd, 3rd and 4th fingers bent and the pinky finger was closed. R8 did not have a ve device to prevent omplained of discomfort when his hand. /21, at 12:00 p.m. R8 was nner. R8 continued to have his tightly and resting in his lap. moving items on his tray with did not move his left hand or	F 6	\$88	Affected residents (R8, R2, and R2 were reviewed for ROM, plan of car- interventions have been reviewed at updated to reflect ROM. ROM for all affected residents was completed. All current residents who have been identified for ROM, interventions and of care have been reviewed and upo All-staff were educated on the import of ROM programs and ensuring resi- are receiving appropriate treatment 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 provide the facility. Audits will be completed weekly x4, monthly x2 and report to for further review and recommendat	e and nd l d plan dated. rtant idents to e ed by QA	

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	-	AND HUMAN SERVICES				FORM	APPROVED
	CARENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIP			0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(0
		245517	B. WING			04/	09/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE		
OAKLAW	N CARE & REHABIL	ITATION CENTER			MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
TAG			TAG		DEFICIENCY)		
F 688	Continued From pa	ae 38	F 6	888	3		
		num Data Set (MDS)					
		1/4/21, indicated R8 required					
		ce with activities of daily living further indicated R8 did not					
	have any impairme	nt in ROM in the upper					
	extremities. The MI cognitive impairment	DS indicated R8 had severe					
	cognitive impairmen						
		d 1/13/21, identified R8 as					
	0	leficit related to dementia and ated to a CVA. R8 requires					
		L's that included extensive					
		per extremity dressing. The					
	left hand and finger	clude R8's limited ROM in the s.					
		dical record did not include by documentation or that R8					
		services for the left hand					
	R8's current physic	ians orders dated 4/9/21, did					
		ers for therapy services, ROM					
	R8's left hand.	to prevent contractures in					
	Interview on 4/7/21.	, at 9;30 a.m. nursing					
	assistant (NA)- B in	dicated R8 has kept his left					
		osed for several months. I complain of pain at times in					
		assisting him with dressing.					
	NA-B further indicat	ted there was no current					
		nted for R8's left hand to as or further impairment in					
	ROM.						
		4/7/21, at 10:00 a.m.					
		N)-A confirmed R8 was hand fully without staff					
		lso confirmed R8's fingers					

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	-	AND HUMAN SERVICES			FORM	05/19/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245517	B. WING			C 09/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	were difficult to ope only be opened par stated R8 did not re or adaptive devices worsening of limited Interview on 4/7/21, medication assistan had limited ROM is several months. TM receive treatment to limited ROM in the indicated R8 always it closed resting on R2 R2's diagnosis repo diagnosis of hemipl the body) following the left side of his b R2's annual Minimu assessment dated a cognitively intact, ha vision, clear speech able to make himse dependent upon sta dressing, toileting a care area assessme potential indicated s recommendations f function. R2 was ab wheelchair in his ro right arm.	en and the pinky finger could tially with assistance. RN-A eceive therapy services, ROM to prevent contractures or d ROM. , at 10:30 a.m. trained nt (TMA)-A indicated R8 has his left hand and fingers for <i>I</i> A-A confirmed R8 did not o prevent contractures/further left hand. TMA-A further s favors his left hand and has his lap.	F 688			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES		TID			0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
			A. BUILDI	ING	a		C
		245517	B. WING				09/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ΟΔΚΙΔΜ	/N CARE & REHABIL	ITATION CENTER			201 OAKLAWN AVENUE		
OAREAN					MANKATO, MN 56001		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
		,			DEFICIENCY)		
F 688	Continued From pa	.ge 40	F 6	88	3		
		5/21, and dated 12/7/19,					
		preceive passive range of					
		his left arm, and also upper					
		n a weight in his right hand. I this was to occur every					
		ment administration record					
		same order. For the months					
		and April 2021, the TAR					
		ed PROM every evening with					
		ee dates in February. R2's					
	refusals of care/trea						
		ast reviewed on 1/6/21, show improvement to the					
		for ADL's and would be free					
		ptoms related to stroke,					
	including contractur	res (tightening of muscles,					
		or skin). The care plan did not					
		m contracture, nor did it ordered on 12/7/19.					
	mention the PROM						
	During an observat	ion and interview on 4/5/21, at					
		wrist and elbow were					
		arm was flexed at the elbow					
		vas flexed at the wrist. R2 was					
		either his elbow or wrist. R2 ontractures for awhile, but not					
	as tight as they wer						
		on 4/7/21, at 7:09 a.m.					
		urse (LPN)-A stated they didn't					
		tive binder (a resource where ROM exercise sheets were					
	kept for staff refere						
		by (OT) staff wrote orders for					
		assistants (NA's) performed					
		v a NA would know which					
	PROM exercises to	o do with a resident if they					

Facility ID: 00038

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES		יחוד	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED	
			A. BOILD	ina			C	
		245517	B. WING				09/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				2	201 OAKLAWN AVENUE			
OAKLAW	/N CARE & REHABIL	ITATION CENTER		Ν	MANKATO, MN 56001			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	х	(EACH CORRECTIVE ACTION SHOULD		COMPLÉTION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIALE	DATE	
			1		,			
F 688	Continued From no	ao 41	– – –					
1 000	Continued From pa	-	F 6	88				
		nce, LPN-A stated NA's had						
	training on PROM.							
	During an interview	on 4/7/21, 7:15 a.m., when						
		order for PROM to occur in						
		ted "it may well be, but it's not						
		ated he did not use weights to						
	strengthen his right	arm either.						
		eview, a nine page, untitled NA						
		7/21, indicated R2 was to						
		is left arm, 10 times daily and						
		e with weight in right hand, he form in bold, capital letters						
		N & ROM MUST BE DONE!!"						
	During record revie	w, a clinic visit dated 3/26/21,						
	indicated R2 had he	emiplegia from a stroke						
		e. Physical and occupational						
		aluate, with the goal of						
		igth so R2 could assist with						
	ADL's.							
	During on interview	on 4/7/21, at 8:06 a.m.,						
		bist (OT)-B stated R2						
		services but when progress						
		he was put on a PROM plan						
	•	emities. OT-B stated OT wrote						
		performed the PROM. OT-B						
	went to R2's room t	o look for his PROM plan,						
		es individualized for R2). R2						
		call receiving a PROM						
		was not able to locate it in his						
		eturned to the nurses station						
		rd, retrieved a binder titled:						
		tive Nursing Communication OT placed all PROM plans for						
		st wing (where R2 resided) in						
		cated R2's PROM exercises,						

Facility ID: 00038

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		AND HUMAN SERVICES					FORM	05/19/2021 APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	0	(X3) DATE COM	0938-0391 E SURVEY PLETED
		245517	B. WING _					C 09/2021
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CO	DE		
OAKLAW	VN CARE & REHABIL	ITATION CENTER			OAKLAWN AVENUE KATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 688	dated 9/14/19, which done to left shoulded and hand. In addition included the use of verified it was R2's During an interview (LPN)-B stated NA's on R2 in the evenin accounted for R2 st when the TAR reflect nursing probably did assumed the NA did LPN-B added that F PROM if offered. During an interview (NA)-J and (NA)-I, the receive PROM, but shift and stated the refused PROM. During an interview asked how NA's km PROM, (NA)-K stat PROM, but sometim a multiple page, unipocket stating "we I When asked if NA's looked at the sheet which indicated PR NA-K stated R2's P and since she didn' not done it. During an interview director of nursing (receive PROM to hit	ch indicated exercises to be er, arm, elbow, forearm, wrist on, exercises for the right hand a three pound weight. OT-B	F 68	38				

Facility ID: 00038

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		AND HUMAN SERVICES			FORM	: 05/19/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	COM	E SURVEY IPLETED
		245517	B. WING			C / 09/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	VN CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 688	nurses oversaw NA done. The DON rev PROM was docume done every day. The completed PROM, I the nurse documen noted there were no in R2's record. Whe was not being done this and admitted it given R2 was cogni it was not being dor nurse asked the NA not verify it had bee R21 R21's diagnosis rep diagnosis of hemipl the body) following the left side of his b R21's quarterly Min assessment dated 2 cognitively intact, ha vision, unclear spee was able to make h dependent upon sta dressing, toileting a self-propel his whee hallways using his r R21's physician ord admission, included indicated physical th therapy (OT) to eval	Vs to ensure PROM was being viewed R2's TAR and stated ented by a nurse as being e DON stated when a NA he/she informed the nurse and ited it on the TAR. The DON o PROM refusals documented en informed R2 stated PROM a, the DON was unaware of was likely not being done, itively intact and would know if ne. The DON stated likely the A if it had been done, but did en done. Dort dated 4/9/21, indicated a legia (paralysis of one side of a stroke. R21 had paralysis on body. imum Data Set (MDS) 2/5/21, indicated R21 was ad adequate hearing and ech, understood others and imself understood. R21 was aff for bed mobility, transfers, and hygiene. R21 was able to elchair in his room and right arm. ders initiated at the time of d standing orders which herapy (PT) and occupational aluate and treat. R21's orders were to document refusals of	F 688			

Facility ID: 00038

If continuation sheet Page 44 of 53

). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
			The Bolebi			С
		245517	B. WING _		04	/09/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
OAKLAV	/N CARE & REHABIL	TATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 688	indicated R21 was a (ROM) daily, and the the restorative book remain free of comp to hemiplegia, woul maximum potential improve current lev needing less assists R21's treatment addindicated R21 was a motion (PROM) in t instructions for this According to the TA done daily in Februar refusals were noted During an interview 2:12 p.m., R21 state or therapy services left arm was observing support attached to had not been able t stroke and had a lo right hand was observing clenched position. During an interview licensed practical n resident-specific PF kept for staff referent occupational therap PROM and nursing it. When asked how PROM exercises to	last reviewed on 2/16/21, to have gentle range of motion e instructions for this were in X. In addition, R21 would oblications or discomfort related d show improvement to with mobility, and would el of function as evidenced by ance with ADL's. ministration record (TAR), to receive passive range of he morning and the were in the restorative binder. .R, PROM exercises were ary, March and April, 2021. No l. and observation on 4/5/21, at ed he did not receive PROM , but he had in the past. R21's red resting on a flat arm his wheelchair. R21 stated he o move his left arm since his t of pain in that arm. R21's erved resting in a slightly on 4/7/21, at 7:09 a.m. urse (LPN)-A stated they didn't tive binder (a resource where ROM exercise sheets were		38		

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		AND HUMAN SERVICES				FORM	APPROVED
	<u>SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
-	F CORRECTION	IDENTIFICATION NUMBER:				(-)	IPLETED
							С
		245517	B. WING			04/	09/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	N CARE & REHABIL	ITATION CENTER			MANKATO, MN 56001		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
E 000		4-					
F 688	Continued From pa	ige 45	F 6	888			
	During an interview	on 4/7/21, at 8:06 a.m.,					
	occupational therap	bist (OT)-B retrieved a binder					
		ition titled: East Wing Communication Book. OT-B					
		I PROM plans for residents on					
	the east wing (when	re R21 resided) in this binder.					
		s PROM plan (exercises), th indicated exercises to be					
		extremities to include elbows,					
	wrists and hands. C	DT-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 r	received PROM to his left arm					
		sometimes he refused due to this occurred, NA-L informed					
	the nurse.	this occurred, NA-L informed					
		on 4/8/21, at 9:58 a.m., I should be receiving PROM,					
		/ director who used to do it					
	stopped due to Cov	vid-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					
		age. FM-C expressed concern ad was becoming contracted.					
		and and stated "look how his					
	fingers are becomin	ng clenched." Then FM-C					
		21's fingers. FM-C indicated					
		1 was not receiving PROM not happy about it; expressing					
		contractures and pain would					
	worsen.						
	During an interview	on 4/9/21, at 7:34 a.m.,					
		were in R21's room to get him					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED
		245517	B. WING				C 09/2021
NAME OF	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	201 OAKLAWN AVENUE		
UAKLAV	VN CARE & REHABIL	TATION CENTER		I	MANKATO, MN 56001		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE			
F 688	out of bed and dres received PROM as NA-J stated therapy sometimes nurses did R21's PROM wi "we pull his arm bac During an interview asked how NA's kn PROM, (NA)-K stat PROM, but sometir a multiple page, un pocket stating "we I When asked if NA's looked at the sheet which indicated: da Restorative commu- recommendations. taken care of R21 in ROM. During an interview director of nursing (did R21's PROM. T according to LPN-B it some time ago du DON looked on the identified in the EM have PROM to his I Wednesday and Fr that OT's recomme have PROM to both day, and that R21 a exercises were occ informed FM-C was more contractures a admitted it was like comments by R21 a	sed. NA-A stated R21 it was listed on his care plan. / usually did the PROM, but or NA's did it. NA-J stated they nen they got him out of bed	F	\$88			

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PRINTED: 05/19/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/19/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	СОМ	E SURVEY PLETED C
		245517	B. WING				09/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAV	VN CARE & REHABIL	ITATION CENTER			201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	asked how she acc stating PROM wasr reflected it was, the asked the NA if it haverify it had been do were no PROM refu- record. During an interview DON indicated she exercise sheets from (PTA)-D which indic to both right and left day. The DON adm between R21's plan PROM exercises, the the NA task list in the an email to OT requi- treat R21 for PROM PROM to both extre- the EMR to ensure The facility policy the Services, with revis- the following: 1. Residents would care as needed to hand independence. 2. Restorative nur- interventions that maccompanied by for services, such as C 3. Restorative goal individualized and r- outlined in the reside 4. The resident wood determining goals a 5. Restorative goal	ounted for R21 and FM-C ounted for R21 and FM-C on't being done when the TAR DON stated the nurse likely ad been done, but did not one. The DON noted there usals documented in R21's on 4/9/21, at 12:37 p.m., the received R21's PROM m physical therapy assistant cated R21 was to have PROM t arms one to two times per itted there were discrepancies of care, OT's recommended he paper NA task sheet, and he EMR, and immediately sent uesting them to evaluate and A. In addition, the DON added emities to the NA task list in it would get done. cled Restorative Nursing ed date of July 2017, indicated d receive restorative nursing help promote optimal safety sing care consisted of nursing hay or may not be rmalized rehabilitation DT. als and objectives were esident-centered, and were	F	588			

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		AND HUMAN SERVICES				FORM	: 05/19/2021 APPROVED . 0938-0391	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245517	B. WING				09/2021	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
OAKLAW	/N CARE & REHABIL	ITATION CENTER			201 OAKLAWN AVENUE MANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 688	Continued From pa maintaining streng	-	F 6	88				
F 693 SS=D	The facility policy til Range of Motion, windicated: 1. Residents will r reduction in range of 2. Residents with treatment and servit a further reduction 3. The care plan winterventions, exerci- maintain, prevent a improve mobility and 4. The care plan winterventions, exerci- maintain, prevent a improve mobility and 4. The care plan winterventions, exerci- measurable goals at and duration of inter measurable goals at and representative these goals and ob 5. Documentation toward the goals ar attempts to address residents condition Tube Feeding Mgm CFR(s): 483.25(g)(4)-(5) E (Includes naso-gas both percutaneous percutaneous endo enteral fluids). Base comprehensive ass ensure that a reside §483.25(g)(4) A res- eat enough alone o enteral methods un	tled Resident Mobility and rith revised date of July 2017, not experience an avoidable of motion (ROM). limited ROM will receive ices to increase and/or prevent in ROM. will include specific cises and therapies to voidable decline in, and/or id ROM. will include the type, frequency, rventions, as well as and objectives. The resident will be included in determining jectives. of the resident's progress and objectives will include s any changes or decline in the or needs. t/Restore Eating Skills 4)(5) nteral Nutrition tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's sessment, the facility must	F 6	593			5/14/21	

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		AND HUMAN SERVICES				FORM	05/19/2021 APPROVED
	<u> SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		E CONSTRUCTION		0938-0391 E SURVEY
-	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245517	B. WING				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER	2.0017			TREET ADDRESS, CITY, STATE, ZIP CODE	04/0	J9/2021
	/N CARE & REHABIL			20	01 OAKLAWN AVENUE		
UARLAN				Μ	IANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 693	Continued From pa clinically indicated a resident; and §483.25(g)(5) A res means receives the services to restore, and to prevent com including but not lim diarrhea, vomiting, abnormalities, and This REQUIREMEN by: Based on observat review the facility fa gastronomy tube (C the abdomen delived directly into the stor medications to 1 of with a G-tube. Findings include: R34's quarterly Min assessment dated severe cognitive im including traumatic indicated R34 was all activities of daily R34's care plan prin potential for alterati for tube feeding for diagnoses of quadr dysphasia. Interven	ge 49 and consented to by the ident who is fed by enteral appropriate treatment and if possible, oral eating skills plications of enteral feeding nited to aspiration pneumonia, dehydration, metabolic nasal-pharyngeal ulcers. NT is not met as evidenced ion, interview, and record iled to ensure placement of a-tube) tube inserted through ering nutrition and medication nach) before giving 1 resident (R34) observed imum Data Set (MDS) 3/10/21, indicated R34 had pairment with diagnoses brain injury. The MDS further totally dependent on staff for	F 6	93		e der for nd had plans d and l ement taff are a-tube nd/or d QA	
		cian orders printed 4/7/21, or G-tube placement prior to					

If continuation sheet Page 50 of 53

STATEMENT OF DEFICIENCIES AND PLANOP CONFIGCTION (MT) PERVORERSUPPLIER(LAIA IDENTIFICATION NUMBER: 245517 (MT) PERVORERSUPPLIER(LAIA BULDING			AND HUMAN SERVICES				FORM	: 05/19/2021 APPROVED . 0938-0391
24517 B. WIND Od409/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTTY, STATE, ZIP CODE COALLAWN CARE & REHABILITATION CENTER STREET ADDRESS, OTTY, STATE, ZIP CODE CO ACLAWN AVENUE OAKLAWN CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFX CROSS-REFERENCE OT OF DEFICIENCIES CROSS-REFERENCE OT THE APPROPRIATE COMPLET TAG SUMMARY STATEMENT OF DEFICIENCIES PREFX CROSS-REFERENCE OT THE APPROPRIATE COMPLET TAG Continued From page 50 meds and feedings with stethoscope. Two times and y. PREFX CROSS-REFERENCE OT THE APPROPRIATE COMPLET O 47/721, at 10:50 a.m. licensed practical nurse (LPN)-A was observed setting up medications and feeding. F 693 F 693 F 693 U PN-A attached a 60 cubic centimeter (cc) syringe to the end of R34's C-tube and pulled back to check tor residual. LPN-A then proceeded to administer R34's medications to followed by his feeding. LPN-A stated fit he residual was greater than 150 cc's the feeding would be held. When interviewed of 49/921, at 11:24 a.m. the director of nursing (DON) confirmed checking placement of a resident's G-tube should be performed through auscutation (listening to sounds arising within organ) with a stethoscope and also checking for residual through the tube. F 755 5/14/21 The policy titide Enteral Tube Medication Admi	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		E CONSTRUCTION	COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STRE. 2IP CODE OAKLAWN CARE & REHABILITATION CENTER 201 OAKLAWN AVENUE MANKATO, MN 56001 MAIN TAY, DI PHERK, MISCONCY MUST BERCEDED BY PULL REGULATIONY MUST AFFERENT OF DEPICIENCIES IEACH DEPICIONY MUST AFFERENCEDED BY PULL REGULATIONY OR LSC IDENTIFYING INFORMATION ID PREFIX TAG PROVIDERS AFFERENCED OR SHOLD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 693 Continued From page 50 mds and feedings with stethoscope. Two times a day AND four times a day. F 693 On 47/21, at 10:50 am. licensed practical nurse (LPN)-A was observed setting up medications and nutritional feeding up decidations and nutritional feeding up decidations followed by his teeding. UPN-A tanched proceeded to administer R34's Clube and pulled back to check for residual. LPN-A confirmed ensuing placement of R34's G-fubb ey checking the residual. LPN-A stated if the residual was greater than 150 cc's the feeding would be held. When interviewed on 4/921, at 11:24 a.m. the director of nursing (DON) confirmed checking placement of aris G-fubb ey checking the residual. LPN-A stated if the residual was greater than 150 cc's the feeding would be held. The policy titled Enteral Tube Medication Administration, dated April 2018, indicated: With gives on, check for proper tube placement using air and auscultation only. Never check placement with water. F 755 5/14/21 F 755 S483.45 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 provide routine and emergency drugs and biologicals to its residents, or obtain them und			245517	B. WING				
OAKLAWN CARE & REHABILITATION CENTER MANKATO, MN 56001 (M) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FULL FEGULATION OR LSC DENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S RIAD OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST DE PRECEDED BY FULL FEGULATION OR LSC DENTIFYING INFORMATION) ID PREFX TAG PREFX (EACH DEFICIENCY MUST DE PRECEDED BY FULL FEGULATION SHOULD BE (EACH DEFICIENCY MUST DE PRECEDED BY FULL FEGULATION OR LSC DENTIFYING INFORMATION) PREFX TAG PREFX (EROS REFERENCE) TO THE APPROPRIATE Op(9) (EROS REFERENCE) (EROS REFERENCE) Op(9) (EROS REFERENCE) (EROS REFERENCE) Op(9) (EROS REFERENCE) (EROS REFERENCE) Op(9) (EROS REFERENCE) <t< td=""><td>NAME OF F</td><td>PROVIDER OR SUPPLIER</td><td></td><td></td><td></td><td></td><td>•</td><td></td></t<>	NAME OF F	PROVIDER OR SUPPLIER					•	
Préčink TAG (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED to THE APPROPRIATE DEFICIENCY) F 693 Continued From page 50 meds and feedings with stethoscope. Two times a day AND four times a day. F 693 F 693 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 residual through the tube. F 755 The policy title Enteral Tube Medication Administration, dated April 2018, indicated: With gloves on, check for proper Lube placement with water. F 755 F 7755 Pharmacy Srvcs/Procedures/Pharmacist/Records SS=F CFR(s): 483.45(a)(b)(1)-(3) \$483.45 Pharmacy Srvices The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in \$483.70(g). F 755	OAKLAW	/N CARE & REHABIL	ITATION CENTER					
 meds and feedings with stethoscope. Two times a day AND four times a day. On 47/21, at 10:50 a.m. licensed practical nurse (LPN)-A was observed setting up medications and nurtitional feeding via G-tube for R34. Prior to administering the medications and feeding, LPN-A attacted 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 proper tube placement using air and auscultation (listening to sounds arising within orly). Never check placement with water. F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records SF Pharmacy Srvcs/Procedures/Pharmacist/Records Ter facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in systams. 	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755	meds and feedings a day AND four time On 4/7/21, at 10:50 (LPN)-A was obser- and nutritional feed to administering the LPN-A attached a 6 syringe to the end of back to check for re proceeded to admin followed by his feed following administra ensuring placemen the residual. LPN-/ greater than 150 co When interviewed of director of nursing (placement of a resi performed through sounds arising with and also checking for The policy titled Em Administration, date gloves on, check for air and auscultation with water. Pharmacy Srvcs/Pr CFR(s): 483.45 (a) (0 §483.45 Pharmacy The facility must pro-	with stethoscope. Two times es a day. a.m. licensed practical nurse ved setting up medications ing via G-tube for R34. Prior e medications and feeding, 60 cubic centimeter (cc) of R34's G-tube and pulled esidual. LPN-A then hister R34's medications ding. When interviewed ation, LPN-A confirmed t of R34's G-tube by checking A stated if the residual was t's the feeding would be held. on 4/9/21, at 11:24 a.m. the (DON) confirmed checking dent's G-tube should be auscultation (listening to in organ) with a stethoscope for residual through the tube. teral Tube Medication ed April 2018, indicated: With or proper tube placement using n only. Never check placement forcedures/Pharmacist/Records b)(1)-(3) Services ovide routine and emergency					5/14/21
		§483.70(g). The fa	cility may permit unlicensed					

Facility ID: 00038

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	05/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE COMF	SURVEY PLETED
		245517	B. WING			C 04/0	<i>,</i> 9/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	••	
OAKLAW	/N CARE & REHABIL	TATION CENTER			01 OAKLAWN AVENUE IANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	a licensed nurse. §483.45(a) Procedu pharmaceutical ser that assure the acc dispensing, and adu biologicals) to meel §483.45(b) Service must employ or obt pharmacist who- §483.45(b)(1) Provi aspects of the prov the facility. §483.45(b)(2) Estat receipt and disposit sufficient detail to e reconciliation; and §483.45(b)(3) Detel order and that an ac- is maintained and p This REQUIREMEN by: Based on observat review, the facility fa- periodic reconciliation medications in 1 of prevent potential log- potential to affect a	der the general supervision of ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. Consultation. The facility ain the services of a licensed des consultation on all sion of pharmacy services in plishes a system of records of ion of all controlled drugs in	F 7	755	Affected E-Kit reviewed and reconcil Pharmacy reached out to applicable vendor and verified that all tags must have an identification number when the received by the facility. All residents have the potential to be affected.	t being	
	medications from the Findings include:				All licensed nursing staff educated or proper reconciliation, storage, and verification of E-Kit identification tag. Nurses advised pharmacy has reach out to the vendor to ensure that all		

Facility ID: 00038

If continuation sheet Page 52 of 53

TATEMENT	OF DEFICIENCIES DF CORRECTION	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	0938-039 E SURVEY PLETED
		245517	B. WING			C 04/09/2021	
	PROVIDER OR SUPPLIER	ITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 01 OAKLAWN AVENUE IANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 755	medication room w practical nurse (LP medication room w with a green unnun included lorazepam medication/controll indicated if the E-K taken out, they put kit until the pharma E-Kit. LPN-B was comes to the facilit she is aware loraze indicated they do n narcotic counts. On 4/9/21 at 10:08 log book on the No lorazepam from the During interview or director of nursing replaced every Mor lorazepam is not ge The policy titled, Co dated 4/14, include medication is not s automatic exchang implement an acco each shift change,	vas conducted with licensed N)-B. Located within the vas a refrigerator with an E-Kit nbered tag present that n (an anti-anxiety ed substance). LPN-B it is opened and something a red numbered tag back on acy comes to change out the unsure how often pharmacy y. LPN-B further indicated epam is in the E-Kit but ot count it daily with the a.m., review of the narcotic orth unit, did not include e E-Kit. n 4/9/21, at 9:36 a.m., the indicated the E-Kit gets nday, and confirmed the etting counted every day. ontrolled Medication Storage, ed: If a scheduled III, IV, and V upplied in a unit dose le system, the facility must ountability record system. At a physical inventory of all ons is conducted by 2	F 75	55	incoming e-kits are numbered with numbered ID tag. Verification will o between two nurses and/or trained licensed staff at change of shift. Director of Nursing or designee wil conduct random audits to ensure p reconciliation, storage, and verifica E-Kit identification tag. Audits will b completed weekly x4, monthly x2 a report to QA for further review and recommendations.	ccur or I roper tion of	

Facility ID: 00038

If continuation sheet Page 53 of 53



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

Oaklawn Care & Rehabilitation Center April 30, 2021 Page 2

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.

Mitig

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

Minnesc	ta Department of He	alth					AT THOVED
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N				(X3) DATE COMP	SURVEY PLETED
		00038		B. WING		04/0	C)9/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OAKLAV	VN CARE & REHABIL	ITATION CENTER		_AWN AVEN O, MN 5600 ⁻	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION OR	DER				
	In accordance with 144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of will corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	ction order has bee y. If, upon reinspec- iency or deficiencie ected, a fine for eac be assessed in acc ines promulgated b artment of Health. The ther a violation has compliance with all rule provided at thalle number indicate ns several items, fa the items will be co Lack of compliance ment of a fine ever	n issued ction, it is s cited h violation ordance by rule of as been e tag d below. ilure to nsidered ce upon rt rule will n if the item				
	You may request a that may result from orders provided tha the Department wit notice of assessme	n non-compliance w t a written request i hin 15 days of recei	vith these is made to ipt of a				
	INITIAL COMMENT On 4/5/21 - 4/9/21, survey was conduc surveyors from the Health (MDH). Your compliance with the following correction indicate in your elect	a licensing and cor ted at your facility b Minnesota Departn facility was found MN State Licensu orders are issued.	nent of NOT in re and the Please				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESE	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 05/10/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 51

Minneso	ta Department of He	alth			FORM	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	of contraction		A. BUILDING:			
		00038	B. WING			C 09/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	VN CARE & REHABIL	TATION CENTER 201 OAKL	AWN AVENU	JE		
UARLAN		MANKATO	O, MN 56001			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE	E APPROPRIATE	DATE
				DEFICIENCY)		
2 000	Continued From pa	ige 1	2 000			
	have reviewed thes	e orders, and identify the date				
	when they will be co					
		plaints were found to be				
		H5517040C (MN00069120), 062982), H5517043C				
		wever NO licensing orders				
	were issued.					
		plaints were found to be				
	(101100001120) and	H5517044C (MN00057214).				
	Minnesota Departm	nent of Health is documenting				
	the State Licensing	Correction Orders using				
		ag numbers have been				
	0	sota state statutes/rules for				
		e assigned tag number eft column entitled " ID Prefix				
		tute/rule out of compliance is				
	listed in the "Summ	ary Statement of Deficiencies"				
		es the "To Comply" portion of				
		r. This column also includes				
		are in violation of the state tement, "This Rule is not met				
		blowing the surveyors findings				
		Method of Correction and				
	Time period for Cor					
	Van hans and th					
		participate in the electronic nsure orders consistent with				
	the Minnesota Dep					
		in 14-01, available at				
	http://www.health.s	tate.mn.us/divs/fpc/profinfo/inf				
		e licensing orders are				
	delineated on the a					
		Ith orders being submitted to Although no plan of correction				
		ate Statutes/Rules, please				
		rected" in the box available for				
nnesota D	epartment of Health		μ			1

If continuation sheet 2 of 51

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00038	B. WING		C 04/09/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
OAKLAV	VN CARE & REHABIL	ITATION CENTER	KLAWN AVENU TO, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 2	2 000			
	State licensure pro completion date, th	n indicate in the electronic cess, under the heading le date your orders will be lectronically submitting to the nent of Health.				
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF IR VIOLATIONS OF TE STATUTES/RULES.				
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			5/14/21
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related segregated or gene care staff	lity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia	a			
	related disorders; (2) assistance with	of Alzheimer's disease and activities of daily living; with challenging behaviors; skills.				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED	
		00038	B. WING			C 04/09/2021	
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
DAKLAW	N CARE & REHABIL	ITATION CENTER	LAWN AVEN O, MN 5600				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE	
2 302	Continued From pa	age 3	2 302				
	trained, the frequer topics covered.	ne categories of employees ncy of training, and the basic I document compliance with					
	by: Based on interview facility failed to ens practical nurse (LP and the administrat Alzheimer's training	ent is not met as evidenced and document review, the sure 3 of 8 employees, licensed N)-B, registered nurse (RN)-A, tor, received dementia or g annually. This had the Il residents who resided in the		corrected			
	Findings include:						
	Alzheimer training t were selected for th five staff were selec care staff. Records been completed for supervisors (the ad	ew of annual dementia and for 2020, three staff records ne category of supervisors and cted for the category of direct indicated this training had not r one staff in the category of dministrator), and incomplete o wo of five staff in the category (LPN-B and RN-A).					
	administrator stated pandemic, the facil had time to comple new deadline of 4/3 If not completed by	on 4/9/21, at 10:30 a.m., the d that due to the Covid -19 ity was not able to ensure staff the the training. Staff have a 30/21, to complete the training. the deadline, those aken off the schedule until					
	SUGGESTED MET	THOD OF CORRECTION:					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED C
		00038	B. WING			09/2021
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
AKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 302	Continued From pa	ge 4	2 302			
	enroll all direct care Alzheimer's training timeline for comple all direct care staff via an audit, and co facility education co	sing (DON) or designee could e staff in the appropriate g courses and notify them of a tion. The DON could ensure complete the missed courses build develop a regular audit of purse completion to be done orientation and throughout the e.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			5/14/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	d t			
	by: Based on observat review, the facility f assess and provide for 1 of 1 resident (ent is not met as evidenced ion, interview and document ailed to comprehensively ongoing treatment for edema R20), who required leg wraps event and treat edema.		corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CONTLECTION	IDENTIFICATION NOMBER.	A. BUILDING: _			
		00038	B. WING			C 09/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
) V K I V W	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU	E		
		MANKAI	O, MN 56001			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE ⁻ DATE
2 830	Continued From pa	age 5	2 830			
	Findings include:					
	diagnosis's of acut doesn't pump enou demand), periphera circulation disorder heart and brain to 2 diabetes mellitus 3 (moderate kidney of left leg below the R20s quarterly Min assessment dated	printed 4/8/21, included e heart failure (heart muscle ugh blood to meet body's al vascular disease (a r that causes blood outside of narrow, block, or spasm), type , chronic kidney disease stage y damage), acquired absence e knee and morbid obesity. imum Data Set (MDS) 2/5/21, included intact airment of range of motion on				
	one side of lower e R20's provider orde compression to right boot, moisturize leg assessing for any a provider if any skin immobilizer to right figure 8, direction f resident to elevate	extremity with limb prosthesis. ers dated 9/22/20, included ht leg in a.m.: Remove Rooke g with moisturizer in his room alteration in skin integrity, notify problems occur. Apply knee t knee. Apply ACE wrap in rom toes to knees. Encourage legs as much as possible. A d 12/29/20, included encourage	,			
	alteration in skin in immobility post hos below the knee am compression to left elevation of lower e tolerated. Care pla deficit related to we the knee amputation	dated 10/15/20 included an tegrity related to weakness and spitalization related to left uputation. Intervention included t extremity, encourage extremities as much as an also included a self-care eakness related to left below on with intervention including personal hygiene and dressing.	k			
		personal hygiene and dressing. a and interview on 4/5/21, at				

If continuation sheet 6 of 51

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00038	B. WING			C 09/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
DAKLAV	VN CARE & REHABIL	ITATION CENTER	LAWN AVENUI 10, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	his room with right I floor, no ace wrap p present. Skin was leg was dependant amputation present indicated he has a l and he is supposed in the morning whe (vascular boot to na doesn't happen ever generally has to asl of the staff don't kn them on it when I h medical field." R20 helps the swelling in the staff do not hav his legs up as they During observation was asleep in his cl ace wrap present o During interview on indicated he has no When asked if staff they don't have time During interview an 7:11 a.m. R20 was dependant with righ nursing assistant (N Rooke boot remain wrap was present o NA-G put on his wr prosthesis. R20 sta to come back in 10	A sitting in a recliner chair in leg dependant and foot on the present and lower leg edema red from mid-calf to foot. Left also and a below the knee with no prosthesis on. R20 lot of swelling in his right foot at the have his right leg wrapped in they remove his Rooke boot aturally warm the limb) but it ery day. R20 indicated he k them to do it and then "half ow how to do do I educate ave zero education in the D indicated the ace wrap really in his feet. R20 further stated e time to remind him to keep are too busy for that. on 4/6/21, at 9:29 a.m., R20 hair with legs dependant and n right lower leg. 4/6/21, at 2:26 p.m., R20 hair with legs today. Fremind him he indicated no e for that. d observation on 4/7/21, at in recliner chair with both legs today. Fremind him he indicated how				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION	COM	E SURVEY PLETED
		00038	B. WING			09/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL		LAWN AVENU	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ae 7	2 830			
	During interview on indicated R20 can g elevate his legs so indicated she hasn	4/7/21, at 7:22 a.m., NA-G get upset when you ask him to I don't ask him to do it. NA-G t wrapped his leg before and e 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.		ו			
	licensed practical n care coordinator, in elevating his legs a	4/8/21, at 10:50 a.m., urse (LPN)-B, who is also the dicated R20 should be nd she would expect staff to iis legs up throughout the shift				
	director of nursing of expect staff to remit throughout the shift on in the mornings she does she a lot	4/8/21, 11:33 a.m., the (DON) indicated she would nd R20 to raise his legs and to have his ace wrap put per orders. The DON did add of refusals documented for ut was not aware staff are not				
	A policy on edema requested but was	prevention and treatment was not provided.				
	The director of nurs review all residents receiving necessary director of nursing of system to conduct of care to ensure a and services are im	THOD OF CORRECTION: sing (DON) or designee, could at risk for edema to ensure y treatment and services. The or designee could develop a random audits of the delivery opropriate monitoring, care plemented. The DON or ort results of audits to quality				

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVEN O, MN 5600 ⁻		
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2 830	Continued From pa	age 8	2 830		
	assurance commit	ee.			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one			
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895		5/14/21
	that is directed tow through positioning implemented and r comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the nursing care plan which			
	receives appropriat	th a limited range of motion te treatment and services to notion and to prevent further of motion.			
	by: Based on observat review, the facility f restore, maintain a motion (ROM) for 3	ent is not met as evidenced ion, interview and document ailed to provide services to nd prevent loss of range of 3 of 3 residents (R8, R2 and range of motion (ROM) and		corrected	
	Findings include:				
	diagnosis (identifie in the medical reco cerebral vascular a	the facility on 2/16, with d on the diagnosis report sheet rd) dated 4/9/21, that included: ccident (CVA) (stroke) alfunction of peripheral nerves			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pa	ige 9	2 895			
		y) chronic kidney disease, itis in the joints) and fracture o	f			
	R8 was observed s lounge watching TV be clenched and re if he could open his to open it partially. noted to be slightly almost completely of splint or any adapting	rvation on 4/7/21, at 9:00 a.m. itting in a wheelchair in the /. R8's left hand was noted to sting on his lap. When asked s right hand he was only able R8's 2nd, 3rd and 4th fingers bent and the pinky finger was closed. R8 did not have a ve device to prevent omplained of discomfort when his hand.				
	observed eating dir left hand clenched R8 was eating and	/21, at 12:00 p.m. R8 was nner. R8 continued to have his tightly and resting in his lap. moving items on his tray with did not move his left hand or entire meal.				
	assessment dated extensive assistant (ADL's). The MDS have any impairme	mum Data Set (MDS) 1/4/21, indicated R8 required be with activities of daily living further indicated R8 did not nt in ROM in the upper DS indicated R8 had severe nt				
	having a self care of mobility deficits rela assistance with AD assistance with upp	ed 1/13/21, identified R8 as deficit related to dementia and ated to a CVA. R8 requires L's that included extensive per extremity dressing. The clude R8's limited ROM in the 's.				
	Review of R8's med	dical record did not include				

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DAKLAW	VN CARE & REHABIL	ITATION CENTER		E		
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2 895	Continued From pa	age 10	2 895			
		py documentation or that R8 services for the left hand				
	not include any ord	tians orders dated 4/9/21, did lers for therapy services, ROM s to prevent contractures in				
	assistant (NA)- B ir hand and fingers c NA-B stated R8 wil his left hand when NA-B further indica treatment impleme	, at 9;30 a.m. nursing ndicated R8 has kept his left losed for several months. Il complain of pain at times in assisting him with dressing. ated there was no current inted for R8's left hand to es or further impairment in				
	registered nurse (F unable to open his assistance. RN-A a were difficult to ope only be opened par stated R8 did not re	A 4/7/21, at 10:00 a.m. RN)-A confirmed R8 was hand fully without staff also confirmed R8's fingers en and the pinky finger could rtially with assistance. RN-A eceive therapy services, ROM s to prevent contractures or d ROM.				
	medication assista had limited ROM is several months. The receive treatment to limited ROM in the	, at 10:30 a.m. trained nt (TMA)-A indicated R8 has s his left hand and fingers for MA-A confirmed R8 did not o prevent contractures/further left hand. TMA-A further rs favors his left hand and has his lap.				
	R2					
	R2's diagnosis repe epartment of Health	ort dated 4/9/21, indicated a				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/09/2021	
		00038	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
OAKLAW	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
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2 895	Continued From pa	ige 11	2 895			
		legia (paralysis of one side of a stroke. R2 had paralysis on oody.				
	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.					
	record (EMR) on 4/ indicated R2 was to motion (PROM) to body exercises with The order indicated evening. R2's treatu (TAR) reflected the of February, March indicated R2 receiv the exception of thr	ed in the electronic medical (5/21, and dated 12/7/19, o receive passive range of his left arm, and also upper n a weight in his right hand. I this was to occur every ment administration record same order. For the months and April 2021, the TAR red PROM every evening with ree dates in February. R2's ed staff were to document atments each shift.				
	indicated R2 would maximum potential from signs and sym including contractu- tendons, ligaments address R2's left an	ast reviewed on 1/6/21, show improvement to the for ADL's and would be free nptoms related to stroke, res (tightening of muscles, or skin). The care plan did not rm contracture, nor did it l ordered on 12/7/19.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00038	B. WING			09/2021
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DAKLAW	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
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2 895	Continued From pa	age 12	2 895			
	2:40 p.m., R2's left observed. R2's left and his right wrist v not able to extend stated he had the c as tight as they we During an interview licensed practical r really use a restora resident-specific P kept for staff refere occupational thera PROM and nursing it. When asked how PROM exercises to	y on 4/7/21, at 7:09 a.m. hurse (LPN)-A stated they didn' ative binder (a resource where ROM exercise sheets were ence). LPN-A stated py (OT) staff wrote orders for g assistants (NA's) performed w a NA would know which o do with a resident if they ence, LPN-A stated NA's had				
	informed he had an the evening, R2 sta	v on 4/7/21, 7:15 a.m., when n order for PROM to occur in ated "it may well be, but it's not ated he did not use weights to t arm either.				
	task sheet dated 4, receive PROM to h upper body exercis daily. At the top of	eview, a nine page, untitled NA /7/21, indicated R2 was to his left arm, 10 times daily and se with weight in right hand, the form in bold, capital letters N & ROM MUST BE DONE!!"				
	indicated R2 had h affecting his left sic therapy were to eva	ew, a clinic visit dated 3/26/21, emiplegia from a stroke de. Physical and occupational aluate, with the goal of ngth so R2 could assist with				

Image: Note of PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE OAKLAWN CARE & REHABILITATION CENTER 201 OAKLAWN AVENUE MANKATO, MN 5001 OVAID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRACEDED BY PLLL PREFX TAG IPPOVIDER'S PLAN OF CORRECTION (EACH DEFICIENCE) 2 895 Continued From page 13 2 895 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 washt 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 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 shed on R2 in the evening. When asked how shed 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 perceive P	DATE SURVEY COMPLETED		CONSTRUCTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ta Department of He T OF DEFICIENCIES OF CORRECTION	STATEMEN
AME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTY, STATE, ZIP CODE 201 OAKLAWN CARE & REHABILITATION CENTER 201 OAKLAWN AVENUE MANKATO, MN 56001 OA(1)D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRETRY TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRETRY TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRETRY TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRETRY TAG PROVIDER'S PLAN OF CORRECTION (EACH OERCIVE ACTION SHOULD BE CROSS REFERENCE TO THE APPROPRIA DEFICIENCY) 2 895 Continued From page 13 2 895 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, for Defi then returned to the nurses station and from a cupboard, retrieved a binder tilled: East Wing Restorative Nursing Communication Book. OT-B Is tated OT placed all PROM plans for residents on the east wing (where R2's 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 uses 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's 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			<u></u>	A. BUILDING: _	IDENTIFICATION NOMBER.		
DAKLAWN CARE & REHABILITATION CENTER 201 OAKLAWN AVENUE MANKATO, MN 5601 Image: Continued Former of Deficiency MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX FAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY 2 895 Continued From page 13 2 895 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 tilded: East Wing Pestorative 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 avere R2 was t	C 04/09/2021			B. WING			
DAKLAWN CARE & REHABILITATION CENTER MANKATO, MN 56001 (X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 2 895 Continued From page 13 2 895 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. <td< th=""><th></th><th></th><th>TATE, ZIP CODE</th><th>DRESS, CITY, S</th><th>STREET AD</th><th>ROVIDER OR SUPPLIER</th><th>IAME OF P</th></td<>			TATE, ZIP CODE	DRESS, CITY, S	STREET AD	ROVIDER OR SUPPLIER	IAME OF P
MANKA10, MN 56001 MANKA10, MN 56001 PROVIDERS PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 2 895 Continued From page 13 2 895 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 RPOM 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.			E	AWN AVENU	ITATION CENTER 201 OAKI		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 2 895 Continued From page 13 2 895 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 tilled: 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 4/8/21, at 7:56 a.m. with (NA)-J and (NA)-I, both were aware R2 was to receive PROM, but reither worked the evening				D, MN 56001	MANKAT		
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(NA)-J and (NA)-I, both were aware R2 was to receive PROM, but neither worked the evening					s were supposed to do PROM ng. When asked how she tating it wasn't being done cted it was, LPN-B stated d not check with the NA, d it and just signed off on it.	(LPN)-B stated NA on R2 in the evenir accounted for R2 s when the TAR refle nursing probably di assumed the NA di LPN-B added that	
refused PROM.					both were aware R2 was to	(NA)-J and (NA)-I, receive PROM, but shift and stated the	

	T OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00038	B. WING			C 04/09/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 895	PROM, (NA)-K stat PROM, but sometin a multiple page, un pocket stating "we When asked if NA's looked at the sheet which indicated PR NA-K stated R2's F and since she didn not done it. During an interview director of nursing receive PROM to h with a weight in his nurses oversaw NA done. The DON rev PROM was docum done every day. Th completed PROM, the nurse documer noted there were n in R2's record. Whe was not being done this and admitted it given R2 was cogn it was not being do nurse asked the NA not verify it had bee R21 R21's diagnosis rep diagnosis of hemip	ow when a resident has ted therapy usually did the mes NA's did it. NA-K removed titled document from her look at this and it will tell us." s provided PROM for R2, she and pointed to R2's page OM to left arm 10 times daily. PROM was done in the evening 't work the evening shift, had on 4/9/21, at 10:15 a.m., the (DON) verified R2 was to is left arm, and upper body right hand. The DON stated A's to ensure PROM was being viewed R2's TAR and stated ented by a nurse as being the DON stated when a NA he/she informed the nurse and the it on the TAR. The DON to PROM refusals documented en informed R2 stated PROM e, the DON was unaware of was likely not being done, itively intact and would know if ne. The DON stated likely the A if it had been done, but did en done.					
		imum Data Set (MDS) 2/5/21, indicated R21 was					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		- (X3) DATE SURVEY COMPLETED C - 04/09/2021	
		00038	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENUE O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 895	Continued From pa	age 15	2 895			
	vision, unclear spe was able to make h dependent upon st dressing, toileting a self-propel his whe hallways using his R21's physician ord admission, included indicated physical t therapy (OT) to eva also indicated staff care/treatments ea R21's plan of care, indicated R21 was (ROM) daily, and th the restorative boo remain free of com to hemiplegia, wou maximum potential	ders initiated at the time of d standing orders which therapy (PT) and occupational aluate and treat. R21's orders were to document refusals of ch shift. last reviewed on 2/16/21, to have gentle range of motion he instructions for this were in k. In addition, R21 would plications or discomfort related ld show improvement to with mobility, and would vel of function as evidenced by				
	indicated R21 was motion (PROM) in instructions for this According to the TA done daily in Febru refusals were noted During an interview 2:12 p.m., R21 stat or therapy services left arm was observing support attached to	Iministration record (TAR), to receive passive range of the morning and the were in the restorative binder. AR, PROM exercises were lary, March and April, 2021. No d. and observation on 4/5/21, at ted he did not receive PROM by but he had in the past. R21's ved resting on a flat arm by his wheelchair. R21 stated he to move his left arm since his				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00038	B. WING	B. WING		C 04/09/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
DAKLAW	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 895	Continued From pa	age 16	2 895				
	right hand was obs clenched position.	erved resting in a slightly					
	licensed practical r really use a restora resident-specific P kept for staff refere occupational thera PROM and nursing it. When asked how PROM exercises to	v on 4/7/21, at 7:09 a.m. hurse (LPN)-A stated they didn' ative binder (a resource where ROM exercise sheets were ence). LPN-A stated py (OT) staff wrote orders for g assistants (NA's) performed w a NA would know which o do with a resident if they ence, LPN-A stated NA's had	t				
	occupational therap from the nurses sta Restorative Nursin stated OT placed a the east wing (whe OT-B located R21's dated 7/29/19, whi done to both upper	v on 4/7/21, at 8:06 a.m., pist (OT)-B retrieved a binder ation titled: East Wing g Communication Book. OT-B II PROM plans for residents or re R21 resided) in this binder. s PROM plan (exercises), ch indicated exercises to be r extremities to include elbows, DT-B verified it was R21's mos	1				
	(NA)-L stated R21 in the evening, but	v on 4/7/21, at 1:54 p.m., received PROM to his left arm sometimes he refused due to this occurred, NA-L informed					
	(LPN)-B stated R2 however the activit	v on 4/8/21, at 9:58 a.m., 1 should be receiving PROM, y director who used to do it vid-19 concerns, and LPN-B d been resumed.					
nnesota D		v on 4/8/21, at 11:25 a.m. R21					

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	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED	
		00038	B. WING			C 04/09/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
AKLAW	/N CARE & REHABIL		LAWN AVENU O, MN 56001	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 895	Continued From pa	age 17	2 895				
	room playing cribba that R21's right har FM-C took R21's h fingers are becomi manually opened F awareness that R2 anymore and was	r (FM)-C were in the activity age. FM-C expressed concern nd was becoming contracted. and and stated "look how his ng clenched." Then FM-C R21's fingers. FM-C indicated 1 was not receiving PROM not happy about it; expressing contractures and pain would					
	(NA)-A and (NA)-J out of bed and dres received PROM as NA-J stated therap sometimes nurses did R21's PROM w	v on 4/9/21, at 7:34 a.m., were in R21's room to get him ssed. NA-A stated R21 a it was listed on his care plan. y usually did the PROM, but or NA's did it. NA-J stated they when they got him out of bed ick to stretch it out."					
	asked how NA's kr PROM, (NA)-K sta PROM, but sometin a multiple page, un pocket stating "we When asked if NA' looked at the sheet which indicated: da Restorative commu- recommendations.	v on 4/9/21, at 8:06 a.m., when now when a resident has ted therapy usually did the mes NA's did it. NA-K removed ntitled document from her look at this and it will tell us." s provided PROM for R21, she t and pointed to R21's page ally ROM to arms in AM. See unication book for OT NA-K stated she had not in a while, so had not done his	1				
	director of nursing did R21's PROM. T according to LPN-E it some time ago d	v on 4/9/21, at 10:28 a.m., the (DON) stated activities staff The DON was informed that 3, activities staff stopped doing ue to Covid-19 concerns. The A task bar (a list of NA tasks					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00038	B. WING			C 04/09/2021	
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		201 OAK	LAWN AVENU				
DAKLAV	/N CARE & REHABIL	ITATION CENTER	O, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 895	Continued From pa	age 18	2 895				
	have PROM to his Wednesday and Fr that OT's recommen- have PROM to both day, and that R21 a exercises were occ- informed FM-C was more contractures admitted it was like comments by R21 activities staff had b asked how she acc- stating PROM was reflected it was, the asked the NA if it h- verify it had been d	IR) and it indicated R21 should left arm on Monday, riday. The DON was informed endations indicated R21 should h arms, one to two times per and his wife stated no PROM curring. The DON was s concerned this will result in and pain for R21. The DON ely not being done, given the and FM-C. The DON assumed been doing PROM. When counted for R21 and FM-C n't being done when the TAR e DON stated the nurse likely ad been done, but did not lone. The DON noted there usals documented in R21's					
	DON indicated she exercise sheets fro (PTA)-D which indic to both right and lef day. The DON adm between R21's plan PROM exercises, t the NA task list in th an email to OT requ treat R21 for PROM PROM to both extra the EMR to ensure	on 4/9/21, at 12:37 p.m., the received R21's PROM im physical therapy assistant cated R21 was to have PROM ft arms one to two times per nitted there were discrepancies n of care, OT's recommended he paper NA task sheet, and he EMR, and immediately sent uesting them to evaluate and <i>A</i> . In addition, the DON added emities to the NA task list in it would get done.					
	Services, with revis the following: 1. Residents wou	sed date of July 2017, indicated Id receive restorative nursing help promote optimal safety	8				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND FLAN	OF CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING:			
		00038	B. WING		C 04/09/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		201 OAK				
AKLAW	/N CARE & REHABIL	LITATION CENTER MANKAT	O, MN 56001			
(X4) ID			ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T		COMPLE DATE
				DEFICIENC	Y)	
2 895	Continued From pa	age 19	2 895			
	2. Restorative nu	rsing care consisted of nursing				
	interventions that r	may or may not be				
		ormalized rehabilitation				
	services, such as (
		als and objectives were resident-centered, and were				
	outlined in the resi					
		rould be included in				
	determining goals	and the plan of care.				
	•	als included maintaining				
		nce, self-esteem and				
	maintaining streng	jth.				
		itled Resident Mobility and				
	•	vith revised date of July 2017,				
	indicated:	not overvience on oveidable				
	reduction in range	not experience an avoidable				
		limited ROM will receive				
		vices to increase and/or preven	t			
	a further reduction					
		will include specific				
		cises and therapies to				
	improve mobility a	avoidable decline in, and/or				
		will include the type, frequency				
		erventions, as well as	,			
	measurable goals	and objectives. The resident				
		will be included in determining				
	these goals and ob					
		n of the resident's progress nd objectives will include				
		is any changes or decline in the	9			
	residents condition					
	SUGGESTED ME	THOD OF CORRECTION:				
		sing or designee, could				
		ies and procedures related to				
		range of motion, could assure				
	proper assessmen epartment of Health	t and interventions are being				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00038	B. WING		C 04/09/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVEN O, MN 5600 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLET DATE
2 895	Continued From pa	ge 20	2 895			
	on the policies and evaluating and mor implementation of t developed, with the brought to the facili Committee for revise	hese policies could be results of these audits being ty's Quality Assurance				
2 900	MN Rule 4658.0528 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			4/12/21
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observati review, the facility fa implement pressure of 1 resident (R84)	ent is not met as evidenced on, interview and document ailed to assess, monitor and e relieving interventions for 1 reviewed who had a stage 4 known risks for pressure ulce	r	corrected		

If continuation sheet 21 of 51

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00038	B. WING		C 04/09/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 21	2 900			
	development. The facility's failures resulted in R84 sustaining harm when the resident developed an unstageable pressure ulcer to the left heel.					
	Findings include:					
	National Pressure Unstageable Press full-thickness skin a skin and tissue loss damage within the because it is obscu slough or eschar is 4 pressure injury w (i.e. dry, adherent, fluctuate) on the he softened or remove					
	diagnoses identifie including: diabetes	to the facility on 8/4/20, with d on the diagnosis report shee mellitus, stage 4 pressure n, kidney failure and protein	t			
	5:00 p.m. R84 was eating. R84 was no boot on the left foo R84's right heel wa pedal of the wheeld on his left heel, but heel. R84 confirme protective device o stated he had frequ	and interview on 4/5/21, at sitting in his wheelchair oted to have a redistribution t and a sock on the right foot. Is pressing against the foot chair. R84 stated he had a sore t was unsure about the right ad staff had been putting a n only the left heel. R84 uent pain in both heels. R84 a had an open sore on his	•			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00038	B. WING		C 04/09/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 22	2 900			
	extensive assistance speech, able to und understood, with ge admission skin assist therefore not identic condition.	ified R84 as requiring ce with mobility, having clear derstand and able to be bod memory recall. The sessment was left "blank" fying R84's current skin				
	8/7/20, identified R pressure ulcer on t identified as measu length, 1.0 cm in w ulcer was further du thickness tissue los margins severely n moist around the e edges slightly rolled present, undermini wound edges beco foul odor. Intervent pressure redistribut pressure relieving n schedule. In addition R84 was admitted	v wound evaluation dated 84 as having a stage 4 he coccyx. The ulcer was uring 2.5 centimeters (cm) in idth, and 2.5 cm in depth. The escribed as having full ss with adipose exposure, nacerated (skin is soft and dges of a wound), wound d, heavy yellowish drainage ng (when tissue under the imes eroded) and as having a ions implemented included: tion cushion on wheelchair, mattress and a repositioning on, the assessment indicated with a significant pressure which was first assessed by				
	identified R84's left No other descriptio documented. In ad	dition, no additional implemented to prevent				
	9/2/20, identified F "boggy". No other of documented. Also,	wound evaluation dated 884's left and right heels were description of the heels was no additional interventions to prevent breakdown of the				

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TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00038	B. WING		- C - 04/09/202	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
νακι αν	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU	E		
		MANKAT	O, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 23	2 900			
	heels.					
	9/14/20, did not add been identified to b There were no add to prevent breakdo Review of a weekly 9/25/20, identified a to the left heel. Mea length, 5.5 cm in w area was described and skin being soft implemented includ boots on at all time Although R84 was "boggy" heels 8/24, implemented until t	wound evaluation dated a suspected deep tissue injury asurements were 3.4 cm in idth and 0.0 cm in depth. The d as being purplish red in color and "boggy". Interventions ded: pressure redistribution s and air mattress on bed. first identified as having /20, no new interventions were his evaluation 9/25/20.				
	10/12/20, identified and worsening. The heels and feet were footboard of the be left heel was descri loss, discolored ski drainage. Measure cm length by 4.5 cr	wound evaluation dated R84's left heel as blistering e evaluation indicated R84's pressing against the d. The pressure ulcer to the ibed as having partial tissue in and scant serosanguinous ments were identified as 5.0 n width and 0.0 cm depth, and ntified as unstageable.				
	(MDS) assessment as having a baselin (BIMS) score of "15 The MDS identified assistance with bed indicated R84 as at indicated R84 had	Amission Minimum Data Set t dated 8/7/20, identified R84 ne interview for mental status 5" (no cognitive impairment). I R84 as requiring extensive d mobility and positioning, t risk for pressure ulcers, and a current stage 4 pressure s included: pressure reducing				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _			С	
		00038	B. WING			04/09/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 24	2 900				
	mattress, chair cushion, turn and repositioning program and pressure ulcer care.						
	dated 2/2/21, identi score of "15." The requiring extensive and positioning, inc pressure ulcers, ar stage 4 pressure u pressure ulcer. (Th was not present on Interventions includ cushion, turn and r treatment dressing Review of the adm	ission Braden scale dated					
	8/7/20, identified R risk for pressure ul- identified R84 as h on the sacrum. In a require extensive a of daily living) that i of bed. Intervention and repositioning p	84 as having mild to moderate cers. The assessment aving a stage 4 pressure ulcer addition, R84 was identified to assistance with ADL's (activities included lifting legs in and out as identified included: turning program, redistribution cushion as, weekly wound assessments	3				
	8/26/20, identified I breakdown related mobility and curren Interventions were skin integrity weekl hrs (hours) and as redistribution cushi	s admission care plan dated R84 as being at risk for skin to acute kidney failure, limited at pressure ulcers. identified as including: monitor ly, turn and reposition every 2 needed (PRN), pressure on to chair, air bed, weekly ent to sacrum and follow wound					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	· · · · · · · · · · · · · · · · · · ·	С	
		00038	B. WING		04/09/2021	
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
DAKLAW	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID			ID			(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 25	2 900			
		aving alteration in skin integrity	,			
		e ulcers on the coccyx and left				
		included: offload left heel with all times, weekly wound				
		itor skin daily, turn and				
	reposition every 2 I	nours, pressure reduction				
		r mattress and encourage R84				
	to accept cares, du	e to occasional refusals.				
	Review of the nurs	ing assistant (NA) resident				
	care sheet dated 4	/2/21, indicated R84 requires				
		Ls, reposition every 2 hours/				
		t to reposition, may be up in 2 hours at a time and blue				
		off heel at all times. There were				
	-	easures identified for the right				
	heel.					
	Review of the curre	ent physicians orders dated				
	-	in /pressure ulcer orders.				
		ded: ensure heels are floated	+			
		boots are in place. ensure fee ne foot board, weekly skin	L			
		every 3 days and as needed				
	to coccyx and woul	nd care to left heel daily and of	f			
	load at all times.					
	During observation	and interview on 4/6/21 at				
	4:00 p.m., R84 was	s observed to be sitting outside				
		aff person. R84 was in the				
		th feet resting on the foot bserved to have thick socks on				
		ot have a redistribution device				
		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				
		eft heel pressure ulcer was				
	measured by licens	sed practical nurse (LPN)-A.				
	The left heel ulcer	measured 5.6 cm by 5.0 cm by	'			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/09/2021	
		00038	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
DAKLAW	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 26	2 900			
	granulation. There the previous week, improved. During t bed and noted to he under the left heel, redistribution device right heel was resti asked LPN-A to che that was covered w the right heel as so hardened skin arou measured a 1/4 inco blanchable. There R84 stated he was Interview with LPN- did not have any or redistribution device there had been no LPN-A stated the w responsible to mon	e to R84's right heel and that previous redness in the area. yound nurse is currently itor R84's skin.				
	and NA-B indicated of the time, but stat occasionally. NA-A to have a blue heel times when in bed. R84 did not have a device for the right R84 utilizes the blu verified staff are no donut properly whe	A 4/7/21, at 9:30 a.m. NA-A R84 will reposition self most ff need to remind him and NA-B confirmed R84 was donut to his left heel at all NA-A and NA-B also verified ny kind of pressure reduction heel. NA-A and NA-B stated e heel donut when in bed, but always able to place the n R84 is up in the wheelchair.				
	p.m. RN-A confirme a pressure redistrib	ed R84 did not have orders for bution device to the right heel, as at risk for pressure ulcers.				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED C
		00038	B. WING	B. WING		09/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DAKLAV	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	assessment identifi interventions imple breakdown. RN-A v identified with "bog unstageable press weeks later. The Director of Nur were interviewed at DON confirmed R8 assessment comple DON also verified F breakdown. The DO were identified to b have been impleme she would expect s skin on admission i interventions neede The facility's 7/18 p Wound Manageme pressure wound ev is identified, notify t provider. Provide in identification of pre associated risk fact SUGGESTED MET The director of nurs review all residents assure comprehen-	ied "boggy" heels with no emented, to prevent skin verified after R84 was gy" heels, R84 developed an ure ulcer to the left heel 6 rsing (DON) and administrator t 1:30 p.m. on 4/8/21. The 4 was admitted without a skin eted until 3 days later. The R84 was at risk for skin ON stated when R84's heels e "boggy" interventions should ented. The DON further stated taff to assess the resident's n order to determine ed to prevent skin breakdown. Policy Skin Assessment and int, included: Initiate a weekly aluation when a pressure ulce the wound nurse and update formation regarding clinical ssure ulcers/injuries and tors. THOD OF CORRECTION: sing (DON) or designee, could at risk for pressure ulcers to sive assessment/ interventions sidents are receiving the	r	DEFICIENC	;Υ)	
	were placed and re necessary treatmen ulcers from develop of pressure ulcers. conduct random au ensure appropriate implemented; to red)			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00038	B. WING		C 04/09/2021
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	01/00/2021
AKLAW	N CARE & REHABIL	ITATION CENTER	LAWN AVEN O, MN 5600	-	
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
2 900	Continued From pa	age 28	2 900		
	assurance commit	ee.			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915		5/14/21
	comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a ne the resident's cond part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toi (4) eat; and (5) use speec	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this aily living includes the ss, and groom; ind ambulate;			
	by: Based on observat review, the facility f completed for 1 of	ent is not met as evidenced ion, interview, and document ailed to ensure nail care was 1 resident (R5) who required oming, and were reviewed for ing.		corrected	
	Finding include:				
	R5's quarterly Minii	mum Data Set (MDS)			

STATE FORM

OVK011

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	AITN (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			C
		00038	B. WING		04/09/2021	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S			
DAKLAW	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	ge 29	2 915			
		12/29/20, indicated R5 had ognition and required limited sonal 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.					
		ekly Skin Inspections indicated d her nails trimmed on 3/9/21.				
	in a wheelchair in h long fingernails with on the ends. R5 wa was. R5 looked at "This one needs to	b.m. R5 was observed seated er room. R5 had extremely a some of them being jagged as unaware when her bath day her right thumbnail and stated, be trimmed". The thumbnail d a v-shape out of part of the				
		p.m., 4/7/21, at 10:10 a.m. and R5 was observed with long,				
	medication aide (Th routinely receive na as needed. TMA-A confirmed they wer further confirmed R	on 4/8/21, at 1:21 p.m. trained MA)-A stated residents il care on their bath day and observed R5's fingernails and e long and jagged. TMA-A 5's bath day was on Tuesday or) and nail care should have that time.				
	manager/licensed p confirmed nail care					

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED	
		00038	B. WING			C 04/09/2021	
	PROVIDER OR SUPPLIER	ITATION CENTER 201 OAK	DDRESS, CITY, S LAWN AVENU O, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 915	The policy titled, B February 2018, did care at the time of SUGGESTED MET The director of nurs review all residents grooming to assure necessary treatmen of nursing or design conduct random au ensure appropriate implemented. The results of audits to	ath, Shower/Tub, revised not address providing nail	2 915				
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv services to maintai and personal and c This MN Requirem by: Based on observat review, the facility f timely toileting and provided for 3 of 3	 b is unable to carry out cing receives the necessary n good nutrition, grooming, oral hygiene. ent is not met as evidenced ion, interview, and document cailed to ensure grooming, incontinence cares were (R34, R41, R43) residents ies of daily living (ADLs), who 	2 920	corrected		5/14/21	

Minnesota Department of Health STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	Сом	E SURVEY PLETED C
		00038	B. WING		04/	09/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ge 31	2 920			
	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 as requiring as hygiene that include assistance due to s	plan dated 12/22/20, identified sistance of staff with personal ed grooming. R34 required elf care deficit related to porosis and cognitive disorder				
		ng assistant (NA) care sheet ed staff to assist R34 with all				
		on 4/5/21, at 2:00 p.m. R34 we long facial hairs on the				
	2:30 p.m. R34 was facial hairs on the c confirmed he was	and interview on 4/6/21, at observed again to have long hin and upper lip. R34 not growing a beard or d like to be shaved.				
		on 4/7/21, at 8:30 a.m R34 ong facial hair on the chin and				
	assistant NA-A and on bath days which Thursdays. NA-A and facial chin and upper should have been s	4/7/21, at 9:00 a.m. nursing NA-B indicated R34 is shaved is on Mondays and nd NA-B confirmed R32's er lip hairs were long and shaved. NA-A and NA-B further unable to shave independently staff assistance.				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:		COM	E SURVEY PLETED C
		00038	B. WING	B. WING		09/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENUE O, MN 56001	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	confirmed R34 requisites aving and should During interview on practical nurse (LPI daily assistance with indicated the NA's is and shaven when re- During observation continued to have le- upper lip. R41 R41's diagnosis rep- indicated diagnoses Parkinson's disease disease, and weaker R41's quarterly Min- assessment dated moderate cognitive and hearing, clear is was able to make he dependent upon sta- locomotion on the u- hygiene. In addition catheter, and was fer R41's plan of care, indicated R41 had fer and was to be check needed. R41 also fer	4/7/21, at 9:00 a.m. NA-C uired staff assistance with be shaved daily if needed. 4/8/21, at 10:00 a.m. licensed N)-A confirmed R34 requires th ADL's. LPN-A further should be checking R34 daily, needed. on 4/8/21, at 2:00 p.m. R34 ong facial hair on the chin and port printed on 4/9/21, s of Alzheimer's disease, e, diabetes, chronic kidney		DEFICIENC		

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00038	B. WING	B. WING		04/09/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
OAKLAV	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	IE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
2 920	Continued From pa	age 33	2 920				
	R41's order summary report printed on 4/9/21, indicated an order for a condom catheter; replace each morning and as needed.						
	task sheet dated 4/	eview, a nine page, untitled /7/21, indicated R41 was to be nours and prn, and was to wea in bed.					
	3/4/21, indicated R- several weeks and to attempt to keep incontinent of urine pink area left media darker edges. Scro erythematous (red candida (yeast infe	eview, a physician note dated 41 had a nasty groin rash for was using a condom catheter the area dry, as he was and stool. Skin: large pale al thigh with slightly raised tum with irregular-shaped skin) rashes consistent with ction). Intertrigo (skin Illy in warm moist areas, such ween folds) groin.					
	(NP) note dated 3/8 and redness to left of prior week, the N that R41's rash was cause of rash conti fecal incontinence. recommended to h	eview, a nurse practitioner 3/21, indicated R41 had a rash thigh and groin. In the middle JP had been notified by staff s not improving; the probable nued to be his urinary and A condom catheter trial was elp manage R41's urinary following day, staff reported the nt well.					
	while R41 was in th of urine was noted bottom fitted sheet measuring approxim	tion on 4/5/21, at 6:17 p.m., ne dining room, a strong smell on his side of the room. R41's had a round damp circle on it mately 12 inches in diameter. had had a damp area on it also nches in diameter.					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	of connection		A. BUILDING: _				
		00038	B. WING			C 04/09/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
		201 OAK	LAWN AVENU	E			
JAKLAW	/N CARE & REHABIL	MANKAT	O, MN 56001				
(X4) ID			ID	PROVIDER'S PLAN OF		(X5) COMPLET	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		DATE	
				DEFICIENC	SY)		
2 920	Continued From pa	age 34	2 920				
	e entinde en rem pe						
	Daily Caro Shoota	for the south wing where R41					
		ne date and times residents					
		nged or toileted. The times					
		on the sheet by NA's. There					
		ling name or initials to indicate					
	who toileted reside	nts.					
		et indicated R41 was toileted a	t				
		during a continuous					
		observation from inside R41's room, or the hallway outside of R41's room from 1:29 p.m. to					
		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						
		anged. Observations and					
	interviews on 4/6/2						
		as laying in bed watching TV.					
		, foul odor of stool.					
		as laying in bed with eyes					
		d come into R41's room, even					
		or was noticeable in the hallway	/				
	outside of his room						
		as laying in bed with his eyes					
	closed.	an interview in the hellway					
		an interview in the hallway					
		om, nursing assistant (NA)-I carry a NA task sheet. When					
		ew the frequency at which a					
		repositioned or toileted, she					
	stated she had that						
		an interview in the hallway					
		n, when asked how she knew					
		quired repositioning or toileting					
		s, (NA)-L removed a sheet from					
		idicated R41 should be toileted	1				
	every two hours an						
		as laying in bed with his eyes					
		d come into his room since					
	observation started	l at 1:29 p.m. despite foul odor					

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00038	B. WING		C 04/09/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OAKLAV	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S		(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
2 920	Continued From pa	age 35	2 920			
	permeating the hall	lway.				
		medication aid (TMA)-A				
		oom to talk to his roommate.				
		participated in activities,				
		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 of					
		vas 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,					
		ersisted. When NA-L checked				
		saturated with urine and stool.				
		t could be saturated with urine				
		ondom catheter, NA-L stated				
		the catheter off. Noted R41's place when NA-L pulled back				
		R41 out of bed, into a				
		the bathroom. R41's fitted				
		led with urine and stool, his				
		ed with urine and stool, as				
	were the cloth unde	erwear with snaps that were				
		ere the rust colored sweat				
		ing. R41's coccyx was				
		reddened area about the size				
		peared raised and bumpy. d in his groin also. While R41				
		oilet, NA-L stripped the bed				
		heets and incontinent pad. The	,			
		ss was not cleaned prior to				
		ts on the bed. Licensed				
	1 0	N)-A went into the bathroom to				
		lom catheter. LPN-A stated the	•			
		ets pulled off when R41				
		R41's urine was toxic to his				
		vhy he wore the condom				
		g cleaned up in the bathroom,				
	epartment of Health	weat pants were put on, and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00038	B. WING		C 04/09/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 36	2 920			
	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.		•			
	9:20 a.m., (NA)-F a to get R41 up for b to be saturated wit removed it. NA-F s had fallen off. NA-f brief had been che According to the D been checked 8:30 prior to NA-F findin TMA-A came into F condom catheter. A applied, which was which was attached The drainage tubin	tion and interview on 4/7/21, at and (NA)-G entered the room reakfast. Observed R41's brief h yellow urine when NA-F stated R41's condom catheter ⁻ did not know when R41's cked or changed last. aily Care Sheet, his brief had a.m. and was dry (40 minutes of it saturated with urine). R41's room and replaced his A new condom catheter was a attached to drainage tubing, d to a urinary drainage bag. Ig was secured to R41's left leg Velcro strap. There was not				

TATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00038	B. WING	B. WING		C 09/2021
IAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
DAKLAV	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	1:30 p.m., R41 was lunch by NA-F who changed once a we assisted R41 into b bedding and chang mattress was not cl asked if the condor NA-F stated it was, his pants to his che came to the room to they first started us improved, but it was it was, but it's still n During an interview 8:22 a.m., a very st in the hallway outsi- room. At 9:16 a.m., R41 up for breakfas and stated the cond and his brief was sa removed the brief a area. The condom TMA-A. Discussed short distance betw appeared to be the frequently being pu were looking into a tubing to prevent th pulled off. During an interview licensed practical n able to toilet himsel movements, and ac on him every two to his brief or toileting	a returned to his room after stated resident bed linen was bek after their bath. As NA-F ed, she noticed the soiled ed it. The bare rubber leaned prior to this. When n catheter was still in place, however when she removed ock brief, it came off. TMA-A o replace it. TMA stated when ing the catheter, his skin had s worse again"it's better thar ot pretty." and observation on 4/8/21, at rong smell of urine was noted de R41's room and in his NA-F entered the room to get st. NA-F looked in R41's brief dom catheter was off again aturated with urine. NA-F and washed R41's perineal catheter was replaced by leg strap with TMA-A and the veen catheter and strap which cause for the catheter lled off. TMA-A stated they different device to secure the se condom catheter from being r on 4/8/21, at 9:58 a.m., urse (LPN)-B stated R41 was f; mostly for bowel ded staff should be checking o three hours, checking either him. LPN-B stated now that catheter, it was easier to			·/	

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00038	B. WING			C 04/09/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
OAKLAV	WN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	ge 38	2 920				
	have expected R41 between 7:00 a.m. informed he had no a.m. LPN-B stated period of time since now, but should be movements sooner toileting where revis on the south unit we pointed out to LPN- were checked, char On 4/7/21, nine res or toileted at 9:00 a a.m. With three or f was it possible to c many residents at t those times were life activity occurred, as sheet right after the During an observat 8:44 a.m., R41 was was still in bed. At 9 when the last time for he was toileted at because it was not Sheet. As R41's roo without prompting, ignored." LPN-B as breakfast yet, or if s yet and R41 replied R41's sheet, his bri sweat pants were v catheter was off ag came into the room to have his brief ch	5:15 a.m., adding she would to be looked at again and 8:00 a.m. LPN-B was of been looked at until 9:15 NA's likely gave R41 a longer a he had a condom catheter looking for incontinent bowel . Daily Care Sheets for ewed with LPN-B for residents ere R41 resided. It was .B that on 4/6/21, 15 residents nged or toileted at 2:00 p.m. idents were checked, changed , and seven residents at 11 four NA's on the south unit, heck, change and toilet that he same time? LPN-B stated kely not the exact times the s NA's don't document on the e task was performed. ion and interview on 4/9/21, at a laying in bed. At 9:47 a.m., he 9:49 a.m., LPN-B was asked R41's brief had been checked and she replied she didn't know documented on the Daily Care om was entered with LPN-B, R41 stated "I'm being sked him if he had been to staff have been into his room in o. When LPN-B pulled back ef, cloth underpants and isibly wet and R41's condom ain. At 10:04 a.m., (NA)-D o and stated R41 had refused ecked and refused to get up earlier. LPN-B stated she					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00038	B. WING		C 04/09/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	TATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 39	2 920			
	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.					
	diagnoses of Alzhei anxiety, weakness dysfunction of the b					
	assessment dated a severe cognitive im rarely understood a	3/18/21, indicated R43 had pairment, does not speak, is nd rarely understands, assist of two for bed mobility,				

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	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00038	B. WING		04/	09/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DAKLAV	VN CARE & REHABIL	ITATION CENTER	LAWN AVENUE O, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ge 40	2 920			
	totally dependent of additional care plan alteration in elimina included a toileting changing every two During observation 5:34 p.m., family m asked them to allow meals and to wake meals and to check so she is awake be	ed 3/28/21, indicated R43 was n staff for toilet use. An dated 7/17/18, indicated an tion related to Alzheimer's and plan for checking and hours and as needed. and interview on 4/5/21, at ember (FM) indicated he has v R43 to rest in bed after R43 about an hour before and change her as needed fore he comes to assist her to lo it and stated "I guess it is st is."				
	 7:30 a.m., R43 brou room from the dinin the television. 8:00 a.m., R43 dozi change. No staff al 8:20 a.m., R43 rem dozing in her chair. R43. 8:50 a.m., R43 rem in her wheelchair. In R43. 9:15 a.m., R43 rem position changes an R43. 10:15 a.m., R43 rem position changes an R43. 10:46 a.m., R43 rem 	y observed on 4/7/21: ught out to the common sitting ig room and placed in front of ing in chair without position oproached R43. ains in common sitting room, No staff have approached hains sitting in common room No staff have approached hains in common room dozing No staff have approached hains in common room, no hd no staff have approached mains in common room, no hd no staff have approached mains in common room, no hd no staff have approached mains sitting in the common have approached R43.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _	·····			
		00038	B. WING			C 04/09/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU	E			
		MANKAI	O, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	age 41	2 920				
	position changes and no staff have approached R43.						
	11:15 a.m., R43 re	emains in common room, no nd no staff have approached					
	11:54 a.m., R43 rei	mains in common room, no nd no staff have approached					
		mily member arrived and R43 g room. Staff assisted residen did not toilet her	t				
	12:55 p.m., R43 re family member.	mains in dining room with s moved back to the common					
	room, remained se	ated in her wheelchair, was ced in front of the television					
	1:38 p.m., R43 rem repositioning or toil 1:59 p.m., the adm	nains in the common room, no eting completed. ninistrator approached and					
		then requested staff lay her R43 appeared tired.					
	member (FM) indic put back in her bec	n 4/7/21, at 1:22 p.m., a family cated he has requested R43 be I in the morning for awhile so hen he comes to assist her to					
	indicated it is easie chair and sit her ou	isten to me. FM further or for them to leave her in her it in the area by the nurses rea) to keep an eye on her but					
	is concerned they of FM indicated he had	don't reposition or toilet her. as spoken to the facility many sue and is very frustrated that i					
	2:02 p.m., nursing	and interview on 4/7/21, at assistant (NA)-A and NA-B, r room and using mechanical					

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
		00038	B. WING	B. WING		C 09/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
OAKLAW	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 42	2 920			
	stool in incontinent around the edges. R43 was last toilete and would have to	R43 had a large brown formed pad with stool dried to the skin NA-A was questioned when ed indicated she was unsure check. Skin was red after n dried stool off buttocks.				
	indicated she was r 8:30 a.m., but not s	4/7/21, at 2:19 p.m., NA-A repositioned at 6:30 a.m., and ince then but should have nd repositioned at 10:30 a.m.				
	indicated they try to and check her pad, if they are short sta	4/8/21, 8:28 a.m., NA-C lay down R43 in the mornings but it doesn't always happen ffed. NA-C indicated she is ember has requested R43 lay als.				
	director of nursing (expect staff to follow	4/08/21, 11:36 a.m., the (DON) confirmed she would w the plan of care and if it ours, they should check and t every two hours.				
	 (ADLs), Supporting indicated: Residents who activities of daily liv the services necess grooming and perse Appropriate can provided for residen ADLs independent accordance with the 	tled Activities of Daily Living , with revised date of 3/2018, are unable to carry out ing independently will receive sary to maintain good nutrition, onal and oral hygiene. re and services will be nts who are unable to carry out y, with consent and in e plan of care, including				
	3. If residents with	ance with elimination (toileting) n cognitive impairment or e, staff will attempt to identify				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00038	B. WING		04/09/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
DAKLAW	VN CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ige 43	2 920			
	assume the resider Approaching the re different time, or ha speak with the resident SUGGESTED MET The director of nurse responsible staff to dependant on facili comprehensively at designee could corresident cares to en needs are met consides designee could rep assurance committed	se of the problem and not just the is refusing or declining care. sident in a different way or at a aving another staff member dent may be appropriate. THOD OF CORRECTION: sing or designee could educate provide care to residents' ty staff, based on residents' ssessed needs. The DON or nduct audits of dependent nsure their personal hygiene sistently. The DON or ort results of audits to quality ee. R CORRECTION: Twenty-one	ı			
2 930	Nasogastric, Gastri Subp. 7. Nasogast and feeding syringes. Based o assessment, a nurs B. a resident v gastrostomy tube o appropriate treatme aspiration pneumon dehydration, metab	ric tubes, gastrostomy tubes, n the comprehensive resident sing home must ensure that: who is fed by a nasogastric or r feeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, polic abnormalities, and lcers and to restore, if	2 930			5/14/21

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00038	B. WING	B. WING		
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE		09/2021
	VN CARE & REHABIL	201 OAK	LAWN AVEN			
UARLAV		MANKAT	O, MN 5600	1		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 930	Continued From pa	ige 44	2 930			
	by: Based on observative review the facility far gastronomy tube (C the abdomen delived directly into the store	ent is not met as evidenced ion, interview, and record ailed to ensure placement of A-tube) tube inserted through ering nutrition and medication mach) before giving 1 resident (R34) observed		corrected		
	Findings include:					
	assessment dated severe cognitive im including traumatic	imum Data Set (MDS) 3/10/21, indicated R34 had pairment with diagnoses brain injury. The MDS further totally dependent on staff for r living.				
	potential for alterati for tube feeding for diagnoses of quadr dysphasia. Interve	nted 4/7/21, indicated a on in nutrition related to need total nutrition secondary to riplegia, epilepsy, and ntions included to check be prior to meds and feedings				
	indicated: Check for	ician orders printed 4/7/21, or G-tube placement prior to with stethoscope. Two times es a day.				
	(LPN)-A was obser and nutritional feed to administering the LPN-A attached a 6 syringe to the end of back to check for re	a.m. licensed practical nurse ved setting up medications ling via G-tube for R34. Prior e medications and feeding, 60 cubic centimeter (cc) of R34's G-tube and pulled esidual. LPN-A then nister R34's medications				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED	
		00038	B. WING			C 04/09/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU	E			
		MANKA	O, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 930	Continued From pa	ge 45	2 930				
	following administra ensuring placement the residual. LPN-/ greater than 150 cc When interviewed of director of nursing (placement of a resi performed through sounds arising with and also checking f The policy titled Ent Administration, date gloves on, check fo	ding. When interviewed ation, LPN-A confirmed t of R34's G-tube by checking A stated if the residual was t's the feeding would be held. on 4/9/21, at 11:24 a.m. the (DON) confirmed checking dent's G-tube should be auscultation (listening to in organ) with a stethoscope for residual through the tube. teral Tube Medication ed April 2018, indicated: With or proper tube placement using a only. Never check placemen	1				
	The director of nurs develop, review, an procedures to ensu are monitored for p feeding tube. The E educate all appropr procedures. The Do systems to ensure	HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re resident with feeding tubes roper placement of that DON or designee could iate staff on the policies and DN could develop monitoring ongoing compliance. The ould report results of audits to ommittee.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21600	MN Rule 4658.133 Emergency Supply	5 Subp. 2 Stock Medications;	21600			5/14/21	
		cy medication supply. A have an emergency					

Minneso	ta Department of He	alth			FORM APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			AL BOILDING		С
		00038	B. WING		04/09/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
DAKLAW	/N CARE & REHABIL	ITATION CENTER		-	
(X4) ID	SUMMARY STA		O, MN 5600	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET
21600	Continued From pa	uge 46	21600		
	the QAA committee	which must be approved by e. The contents, maintenance, ergency medication supply art 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			corrected	
	medications in 1 of prevent potential lo potential to affect a	on of controlled or narcotic 1 emergency kit (E-Kit) to ss or diversion. This had the ny of the 52 residents present nay require controlled ne E-Kit.			
	Findings include:				
	medication room w practical nurse (LP medication room w with a green unnum included lorazepam medication/controlle indicated if the E-K taken out, they put kit until the pharma E-Kit. LPN-B was to comes to the facility she is aware loraze	a.m., a tour of the North unit as conducted with licensed N)-B. Located within the as a refrigerator with an E-Kit nbered tag present that n (an anti-anxiety ed substance). LPN-B it is opened and something a red numbered tag back on acy comes to change out the unsure how often pharmacy y. LPN-B further indicated epam is in the E-Kit but ot count it daily with the			
		a.m., review of the narcotic rth unit, did not include e E-Kit.			
nocoto D		4/9/21, at 9:36 a.m., the indicated the E-Kit gets			
TE FORI	•		6899	OVK011 If	continuation sheet 47

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	<u></u>			
		00038	B. WING			C 04/09/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
AKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU	E			
			O, MN 56001	PROVIDER'S PLAN OF	CORRECTION	()(5)	
(X4) ID Prefix Tag	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21600	Continued From pa	age 47	21600				
		nday, and confirmed the etting counted every day.					
	dated 4/14, include medication is not s automatic exchang implement an acco each shift change,	ontrolled Medication Storage, ed: If a scheduled III, IV, and V upplied in a unit dose ge system, the facility must buntability record system. At a physical inventory of all ions is conducted by 2 tion passers.					
	The administrator, consultant pharma and revise policies processes for mon stored in the E-Kit. consultant pharma random observatio compliance. The a	THOD OF CORRECTION: director of nursing (DON) cist or designee could review and procedures to include itoring controlled substances The administrator, DON, cist or designee could perform nal audits to ensure dministrator, DON or designee s of audits to quality assurance					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21805	MN St. Statute 144 Residents of HC F	I.651 Subd. 5 Patients & ac.Bill of Rights	21805			5/14/21	
	residents have the courtesy and respe	ous treatment. Patients and right to be treated with act for their individuality by ersons providing service in a					
	This MN Requirem	ent is not met as evidenced					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		00038	B. WING	B. WING		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
DAKLAW	/N CARE & REHABIL	ITATION CENTER	(LAWN AVEN (O, MN 5600			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	ge 48	21805			
	review, the facility f atmosphere for 1 o	ion, interview and document ailed to provide a dignified f 1 resident (R43) observed to catheter bag which was		corrected		
	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.					
	assessment dated severe cognitive dis rarely understood a two for transfers an	num Data Set (MDS) 3/18/21, indicated R43 had sorder, does not speak, is and requires extensive assist o d bed mobility, is totally for locomotion and has an	f			
	5:34 p.m., R43 was wheelchair past the computer and activ residents were sittin a cover on on the u bag). A family men catheter bag is nev the color of urine w bother him. FM fur	and interview on 4/5/21, at wheeled down a hallway in a common room (television, ities area), where four other ng, to the dining room without rine collection device (cathete nber (FM) indicated R43's er covered. He just notices hen he is here, but it doesn't ther indicated if R43 still had s, it would bother her.				
	was wheeled to the catheter bag uncov	on 4/5/21, at 6:30 p.m., R43 common area with the ered under her chair and residents were present in the a.				

If continuation sheet 49 of 51

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					С	
		00038	B. WING		04/	09/2021
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
DAKLAW	/N CARE & REHABIL	ITATION CENTER	LAWN AVENU O, MN 56001	E		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE	(X5) COMPLET DATE
TAG			TAG	DEFICIENC		5/112
21805	Continued From pa	age 49	21805			
	was in the commor uncovered catheter	on 4/6/21 at 2:18 p.m., R43 n area in her wheelchair with r bag under the chair and esidents were present as bingo at this time.				
	was in the commor	on 4/7/21 at 7:09 a.m., R43 n room with three other overed catheter bag attached air and visible.				
	assistant (NA)-a in come with a cover	n 4/7/21, at 2:02 p.m., nursing dicated most catheter bags but this one must not have, bu e the catheter bags covered.	t			
	was wheeled from multiple residents p	n on 4/8/21, at 8:22 a.m., R43 the main dining area with present, down the hallway to with catheter bag under the red and visible.				
	10:38 a.m., NA-E v R43's room and wa to assist R43 to he generally when res rooms the catheter added that some catheter	and interview on 4/8/21, at wheeled R43 down hallway to as assisted by NA-D using lift r bed. NA-D indicated idents are taken out of their bag is covered. NA-D further atheter bags come with a on't and apparently this one				
	director of nursing	n 4/08/21, at 11:36 a.m., the confirmed catheter bags when residents leave their				
		dure related to ensuring covered was requested and no	t			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
	OF CONTLECTION	IDENTIFICATION NOMBER.	A. BUILDING: _				
		00038	B. WING			C 04/09/2021	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
		201 OAK	LAWN AVENU				
AKLAW	N CARE & REHABIL	ITATION CENTER MANKAT	O, MN 56001				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
RÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	THE APPROPRIATE	COMPLE DATE	
				DEFICIENC	:Y)		
21805	Continued From pa	age 50	21805				
	SUGGESTED METHOD OF CORRECTION:						
		sing (DON) or designee, could					
		with indwelling Foley ector of nursing or designee					
		stem to conduct random audits	:				
		are to ensure appropriate care					
	and services are in	nplemented. The DON or					
		ort results of audits to quality					
	assurance commit	lee.					
	TIME PERIOD FO	R CORRECTION: Twenty-one					
	(21) days.	· · · · · · · · · · · · · · · · · · ·					

DEPART	MENT OF HEALTH	AND HUMAN SERVICES	-				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245517	B. WING			04/	08/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ΟΔΚΙ ΔΜ	/N CARE & REHABIL	ITATION CENTER			01 OAKLAWN AVENUE		
OANEAN				N	IANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K 0	000			
	FIRE SAFETY						
	Minnesota Departm Fire Marshal Divisio Oaklawn Care and in compliance with participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Code (LSC), Chapt and the 2012 editio Facilities Code. THE FACILITY'S P ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, Rehab Center was found not the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety er 19 Existing Health Care n NFPA 99, Health Care OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
		SE EPOC, A PAPER COPY OF RRECTION IS NOT					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY					
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

F5517031

Electronically Signed

05/10/2021

PRINTED: 05/25/2021

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.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/25/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245517	B. WING		04/	08/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
OAKLAW	/N CARE & REHABIL	ITATION CENTER		201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K 000)		
	Health Care Fire Ins State Fire Marshal 445 Minnesota St., St Paul, MN 55101-	Division Suite 145				
	By email to:					
	FM.HC.Inspections	@state.mn.us				
		RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION:				
		ption of the corrective action correct the deficiency.				
		sures that will be put in place ency does not reoccur.				
		facility plans to monitor future sure solutions are sustained.				
	4. Identify who is re actions and monitor	sponsible for the corrective ring of compliance.				
	5. The actual or pro the remedy.	posed date for completion of				
	partial basement fa with one building ac The facility is fully s determined to be of The entire facility is The facility has a fir detection in the corr	Rehab is a one-story with cility was constructed in 1964, ddition constructed in 1995. prinklered, and was f Type II (111) construction. fully fire sprinkler protected. re alarm system with smoke ridors and spaces open to the nonitored for automatic fire				

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If continuation sheet Page 2 of 4

		AND HUMAN SERVICES				FORM	05/25/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Main Building 01		E SURVEY IPLETED
		245517	B. WING			04/	08/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
OAKLAW	/N CARE & REHABIL	ITATION CENTER			01 OAKLAWN AVENUE IANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa department notifica	-	KC	00			
	The facility has a ca census of 49 at tim	apacity of 70 beds and had a e of the survey.					
K 321 SS=D	NOT MET as evide Hazardous Areas -	5	КЗ	21			5/14/21
	having 1-hour fire r fire rated doors) or system in accordar When the approved system option is us separated from oth partitions and doors Doors shall be self- and permitted to ha protective plates the from the bottom of Describe the floor a	re protected by a fire barrier esistance rating (with 3/4 hour an automatic fire extinguishing nee with 8.7.1 or 19.3.5.9. d automatic fire extinguishing ed, the areas shall be er spaces by smoke resisting s in accordance with 8.4. cclosing or automatic-closing ave nonrated or field-applied at do not exceed 48 inches					
	 b. Laundries (larger c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo) 	Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces					

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Facility ID: 00038

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		AND HUMAN SERVICES			FOR	D: 05/25/2021 M APPROVED <u>O. 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 0		ATE SURVEY OMPLETED	
		245517	B. WING		0	4/08/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
K 321	Hazard - see K322 This REQUIREME by: Based on observa failed to maintain h edition), Life Safety 19.3.2.1.3, 19.3.6.3 could affect all resi- compartment. FINDINGS INCLUE On facility tour betw on 04/08/2021, ob North Soiled Linen latch when closed. This deficient pract	classified as Severe) NT is not met as evidenced tion and interview, the facility azard rooms NFPA 101 (2012 (Code, sections 19.3.2.1, 8.5. This deficient practice dents within the smoke	К 3	North Soiled Line repaired to ensur- latching when clo Education provide the importance of doors are positive Maintenance Dire conduct random a linen room doors when closed. Auc weekly x4, month	en Room door was e it was positively used. ed to all staff regarding f ensuring the linen roor ely latching when closed ector or designee will audits to ensure facility are positively latching dits will be completed aly x2 and report to QA and recommendations.	1.	

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