

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PYGU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00038

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245517		3. NAME AND ADDRESS OF FACILITY (L3) OAKLAWN CARE & REHABILITATION CENTER		4. TYPE OF ACTION: <u>7</u> (L8)	
2.STATE VENDOR OR MEDICAID NO. (L2) 953692000		(L4) 201 OAKLAWN AVENUE		1. Initial 2. Recertification	
		(L5) MANKATO, MN (L6) 56001		3. Termination 4. CHOW	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 07/01/2015		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)		5. Validation 6. Complaint	
		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA		7. On-Site Visit 9. Other	
6. DATE OF SURVEY 01/31/2017 (L34)		02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF		8. Full Survey After Complaint	
8. ACCREDITATION STATUS: <u> </u> (L10)		03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC		FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC		04 SNF 08 OPT/SP 12 RHC 16 HOSPICE		09/30	
2 AOA 3 Other					
11. LTC PERIOD OF CERTIFICATION		10. THE FACILITY IS CERTIFIED AS:			
From (a) :		X A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u>			
To (b) :		Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit			
		Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director			
		<u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size			
12.Total Facility Beds 77 (L18)		<u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room			
13.Total Certified Beds 77 (L17)		B. Not in Compliance with Program			
		Requirements and/or Applied Waivers: * Code: A* (L12)			
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS
18 SNF	18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1): (L15)
	77				
(L37)	(L38)	(L39)	(L42)	(L43)	

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

17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY APPROVAL	Date:
<u>Kathy Lucas, Unit Supervisor</u>	<u>01/31/2017</u>	<u>Kate JohnsTon, Program Specialist</u>	<u>02/08/2017</u>
	(L19)		(L20)

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

19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : <u> </u>	
<u>X</u> 1. Facility is Eligible to Participate					
<u> </u> 2. Facility is not Eligible					
		(L21)			
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988	23. LTC AGREEMENT BEGINNING DATE	24. LTC AGREEMENT ENDING DATE	26. TERMINATION ACTION: (L30)		
(L24)	(L41)	(L25)	VOLUNTARY <u>00</u> INVOLUNTARY		
			01-Merger, Closure 05-Fail to Meet Health/Safety		
			02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement		
			03-Risk of Involuntary Termination OTHER		
			04-Other Reason for Withdrawal 07-Provider Status Change		
			00-Active		
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTIONS		30. REMARKS		
	A. Suspension of Admissions:				
(L27)	(L44)				
	B. Rescind Suspension Date:				
	(L45)				
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.		31. RO RECEIPT OF CMS-1539		
	06201		32. DETERMINATION OF APPROVAL DATE		
(L28)	(L31)		01/23/2017		
			(L33)		
			Posted 02/09/2017 Co.		
			DETERMINATION APPROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245517
February 8, 2017

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

Dear Ms. Peterson:

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

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

Effective January 17, 2017 the above facility is certified for or recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Oaklawn Care & Rehabilitation Center

February 8, 2017

Page 2

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a large loop at the end.

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 2, 2017

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

RE: Project Number

Dear Ms. Peterson:

On December 23, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 8, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 25, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 25, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 8, 2016, effective January 17, 2017 and therefore remedies outlined in our letter to you dated December 23, 2016, will not be imposed.

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.

Feel free to contact me if you have questions.

Oaklawn Care & Rehabilitation Center

February 2, 2017

Page 2

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston", with a large, sweeping flourish extending to the right.

Kate JohnSTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245517	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 1/31/2017	Y3
NAME OF FACILITY OAKLAWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0431	Correction	ID Prefix F0465	Correction
Reg. # 483.10(f)(1)-(3)	Completed	Reg. # 483.45(b)(2)(3)(g)(h)	Completed	Reg. # 483.90(h)(5)	Completed
LSC	01/17/2017	LSC	01/17/2017	LSC	01/17/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KL/KJ	DATE 02/02/2017	SIGNATURE OF SURVEYOR 38202	DATE 01/31/2017	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/8/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245517	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 1/25/2017
NAME OF FACILITY OAKLAWN CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	01/17/2017	LSC K0781	01/17/2017	LSC K0918	01/17/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0920	01/17/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) KL/KJ	DATE 02/02/2017	SIGNATURE OF SURVEYOR 35482	DATE 01/25/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/7/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PYGU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00038

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		(L5) MANKATO, MN (L6) 56001		3. Termination 4. CHOW	
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		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA		7. On-Site Visit 9. Other	
6. DATE OF SURVEY 12/08/2016 (L34)		02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF		8. Full Survey After Complaint	
8. ACCREDITATION STATUS: <u> </u> (L10)		03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC		FISCAL YEAR ENDING DATE: (L35)	
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2 AOA 3 Other					
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From (a) :		A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u>			
To (b) :		Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit			
		Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director			
		<u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size			
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13.Total Certified Beds 77 (L17)		X B. Not in Compliance with Program			
		Requirements and/or Applied Waivers: * Code: B* (L12)			
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS
18 SNF	18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1): (L15)
	77				
(L37)	(L38)	(L39)	(L42)	(L43)	

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

17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY APPROVAL	Date:
<u>Christine Bodick-Nord - HFE - II</u>	<u>12/29/2016</u>	<u>Kate Johnston - Program Specialist</u>	<u>01/23/2017</u>
(L19)		(L20)	

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

19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : <u> </u>	
☒ 1. Facility is Eligible to Participate					
<u> </u> 2. Facility is not Eligible					
		(L21)			
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(L24)	(L41)	(L25)	VOLUNTARY <u>00</u> INVOLUNTARY		
			01-Merger, Closure 05-Fail to Meet Health/Safety		
			02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement		
			03-Risk of Involuntary Termination OTHER		
			04-Other Reason for Withdrawal 07-Provider Status Change		
			00-Active		
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTIONS		30. REMARKS		
(L27)	A. Suspension of Admissions:				
	(L44)				
	B. Rescind Suspension Date:				
	(L45)				
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.		31. RO RECEIPT OF CMS-1539		
	06201		32. DETERMINATION OF APPROVAL DATE		
(L28)	(L31)		(L32)		
			(L33)		
			Posted 01/26/2017 Co.		
			DETERMINATION APPROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 23, 2016

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

RE: Project Number S5517028

Dear Ms. Peterson:

On December 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Kathy Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 17, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 17, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 8, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston", with a stylized flourish extending from the end.

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 12/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/08/2016
NAME OF PROVIDER OR SUPPLIER OAKLAWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents choices were honored related to specific times to go to bed for 1 of 3 residents (R47), reviewed for choices.	F 242	Nursing order for R47 resident's TV to be turned off was discontinued. Resident will be allowed to choose bedtime and watch TV as desired.		1/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/28/2016

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

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F 242	Continued From page 1 Findings include: R47's annual Minimum Data Set (MDS), dated 8/30/16, indicated R47 was cognitively intact, had no guardian or legally authorized representative, and had adequate hearing with no difficulty in normal conversation or listening to the television. The MDS further indicated it was very important for R47 to choose her own bedtime and to keep up with the news. During an interview on 12/6/16, at 3:06 p.m. R47 stated she was not allowed to choose when she went to bed at night because the staff turned her television off every night at 10:00 p.m. R47 stated, "I like to watch the news at 10:00, but if I ask to leave it on, they get mad about that." R47's order summary report dated 11/5/16, included an order dated 9/6/16, directing staff to "Ensure t.v. [television] is turned off, no later than 2200 [military time for 10:00 p.m.] and remains off through the night, every evening and night shift for safety." Review of R47's progress notes and physician assistant notes from 9/6/16 lacked documentation addressing the above order. R47's care plan did not include information regarding R47's television to be off at 10:00 p.m. R47's nursing assistant care sheet, undated, included, "TV [television] to be turned off at 10:00 p.m." During an interview on 12/7/16, at 3:17 p.m. nursing assistant (NA)-A stated she worked the	F 242	Resident Rights were reviewed with residents at resident council in December. Nursing staff will be educated on resident's rights to make choices about aspects of their life in the facility. Administrator or designee will select a random sample of residents to be interviewed monthly x 3 to ensure staffs are respecting resident's right to make choices. Results will be reported to QA committee for analysis and further recommendations.		

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F 242	Continued From page 2 evening shift and R47's roommate had difficulty sleeping sometimes so, "A couple months ago, it was decided that her [R47] TV needs to be off at 10 [10:00 p.m.], so when we do rounds, we shut it off." On 12/8/16 at 10:01 a.m., social services director stated, "We have a rule here that the TVs have to be off at 10 if they have a roommate. We have that general rule so as not to disturb their sleep." During an interview on 12/8/16, at 1:46 p.m., director of nursing (DON), stated, "I'm the one that put the order in," but she was unable to determine the reason for the order. DON indicated she had reviewed R47's physician's dictation, R47's care plan, R47's progress notes, and R47's roommate's progress notes. DON stated, "At first I thought it was a fall intervention, but it's not. I don't see a reason." DON indicated the facility did not have a policy or a rule limiting television usage and stated, "She [R47] can watch TV as long as she wants. I have no idea why it was put on. It could have been for someone else." A policy regarding resident choices was requested. The facility provided the Combined Federal and State Bill of Rights, revised 11/28/16, which included under Self-Determination, "1. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part. 2. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident."	F 242			

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F 431 F 431 SS=D	Continued From page 3 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals.	F 431 F 431			1/17/17

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F 431	Continued From page 4 (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: F 431 Based on observation, interview and document review, the facility failed to identify and dispose of expired medications in 1 of 2 medication storage rooms reviewed. Findings include: On 12/8/16, at 11:59 am south unit medication storage room was reviewed with registered nurse (RN)-A. The medication storage cupboard was observed to contain four unopened bottles of pink bismuth, each with an expiration date of 12/15 and three bottles of unopened liquid acetaminophen with an expiration date of 11/16. On 12/8/16, at 11:59 am RN-A verified the four bottles of bismuth and three bottles of acetaminophen medications were outdated and	F 431	Expired medications were disposed of. All stock medications ☐ expiration dates were reviewed and outdated medications were disposed of. Nursing staff were re-educated on checking expiration dates on all medications, including unopened house stock, and disposing of outdated medications. DON or designee will conduct audits of medication supply weekly x4, then monthly x3 with results reported to QA committee for analysis and further recommendation.		

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F 431	Continued From page 5 should have been removed from the medication storage cupboard. On 12/8/16, at 11:59 am licensed practical nurse (LPN)-A observe the pink bismuth bottles and stated "those are really old". The facility policy titled, House Stock Mediations dated 01/01/13, identified, "7. Facility should ensure that House Stock Medications are stored under proper storage conditions, in accordance with Applicable Law and the State Operations Manual."	F 431			
F 465 SS=F	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner. This had the potential to effect all 61 residents receiving meals from the kitchen. Findings include: During the initial tour of the kitchen on 12/5/16, at	F 465	The stove and ovens were cleaned. The electric can opener, food processor and mixer were also cleaned. The cooler and dry storage floors were swept and mopped. All equipment will be cleaned thoroughly after each use. Floors will be cleaned daily and after spills as they happen. The kitchen maintenance schedule was		1/17/17

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F 465	Continued From page 6 3:25 p.m. with the certified dietary manager (CDM) the following sanitation concerns were observed. Convection oven has a pipe connected, which is located on the top left side of the oven. The pipe and connector was covered with dust, which extended out from the pipe and connector approximately 1 centimeter (cm). The front of the oven was splattered with reddish-brown spots and food particles across the entire front of the oven. The spots ranged from speck sized to approximately 1/2 cm in diameter. The stove top and two ovens had a continuous layer of grease on the front below the knobs, with a thick black grease layer caked on the top near the burners. Along the inside of the ledge of the stove next to the burners, a black grease buildup. The ledge above the stove had dust and crumbs scattered across it. The front of both oven doors as well as the oven handles were covered in grease and dirt. The electric can opener had brown buildup around the metal cutting area. A food processor was noted on the counter, uncovered, with the knobs in front dirty with brown and white substance on and around the knobs. A large mixer was also noted on the counter, covered with a plastic cover. When the cover was removed, the mixer was noted to have sediment on the outside of the base, with the legs of the mixer stuck to the counter surrounded by approximately 1/4 cm layer of brown/black sticky substance, which prevented the mixer from being	F 465	updated so food processor will be included. Dietary staff were re-educated on the policy and cleaning schedule and on the importance of cleanliness of the kitchen. CDM or designee will conduct kitchen audits for cleanliness weekly x4, then monthly x3 with results reported to QA committee for analysis and further recommendations.		

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F 465	Continued From page 7 lifted off the counter. The walk in cooler was noted to have a red and yellow substance spilled on the floor. The dry storage area was noted to have food spilled on the ground, appearing like cereal. The CDM grabbed the broom and cleaned this up during our tour. During interview on 12/5/16 at 3:25 p.m. CDM stated the can opener was to be cleaned after each use, and was not acceptable in the current condition. She also stated the food processor was to be cleaned after each use and was not cleaned as was expected During interview on 12/7/16, at 12:46 p.m. CDM stated she would like to see the oven cleaner, and verified the outside needs a "thorough cleaning." She stated it has not been getting marked off as complete on the cleaning schedule. The CDM described the buildup on the stovetop as bubbling, stating this has been a problem since shortly after the equipment was purchased, and the only way to clean it was to sand blast it. CDM stated it is her expectation that this be cleaned after each use, and deep cleaned monthly, and that it would not be acceptable in the current condition. She stated the large mixer was not affixed to the counter, and verified it was not able to be moved due to the buildup around the feet. She stated it is her expectation that the mixer be moved when cleaning, to be cleaned beneath and around the feet. The walk in cooler was reported by the CDM to have been mopped, but stated it appears some was missed as the red and yellow spills remained under the shelves. CDM stated it is her expectation that staff clean	F 465			

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F 465	Continued From page 8 spills in the dry storage area as they happen. Review of facility Maintenance Schedule from July 2016, through December 2016, identified the following: Convection oven - instructed staff to clean the inside/outside with hot soapy water weekly. This was documented as completed once on 9/26/16. Pipe down by oven - instructed staff to wipe down weekly or as needed. This was marked as completed on 7/1/16, 7/12/16, 8/7/16, 8/16/16, 9/12/16, 11/2/16, 12/1/16 for a total of 7 of 23 opportunities. Range grates / back of stove - instructed staff to clean daily, season as needed, and wash weekly. This was marked as completed on 7/10/16, and 10/13/16. Slow oven under grill - instructed staff to clean inside/outside weekly with hot/soapy water weekly. This was marked as completed on 9/26/16. Shelf above range - instructed staff to wipe down weekly. This was marked as completed on 9/12/16. Can openers - instructed staff to wipe down daily. This was marked as completed on 7/10/16, 7/12/16, 8/7/16, 9/12/16, 10/26/16, 11/2/16, and 12/1/16. Food processor - was not included on the facility Maintenance Schedule. Mixer - instructed staff to send through the wash	F 465			

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F 465	Continued From page 9 after each use and to check the rim guard and wash after use. This was marked as completed on 7/6/16, 8/16/16, 9/12/16, 11/2/16, 12/1/16. Freezer/cooler - instructed staff to keep clean daily, and mop weekly. This was marked as completed on 7/1/16, 7/7/16, 7/12/16, 8/8/16, 8/16/16, 8/27/16, 9/2/16, 9/12/16, 9/16/16, 10/24/16, 11/3/16, 11/9/16, 12/1/16, and 12/4/16. The facility policy that was provided failed to address the frequency that the kitchen equipment was to be cleaned.	F 465			

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F3517026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/07/2016
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 07, 2016. At the time of this survey, Oaklawn Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Oaklawn Health Care Center was constructed as follows: The original building was constructed in 1964, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II (000) construction; The 1995 building Addition is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 77 beds and had a census of 61 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/07/2016
NAME OF PROVIDER OR SUPPLIER OAKLAWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 211 SS=F	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to be in accordance with Chapter 7, which states, all means of egress is to be continuously maintained free of all obstructions to full use in case of emergency. This deficient practice could affect 61 of the 61 residents. Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/08/2016, observation revealed a cart of folding chairs stored within the North Patio Exit Egress. This deficient practice was verified by the Facility Maintenance Director.	K 211	The folding chairs were removed from the North Patio Exit Egress. Maintenance Director will complete audit for egress being free of all obstructions monthly x3 with results reported to QA committee for analysis and further recommendations. Staff will be educated in the all staff meeting on the means of egress being continuously free of all obstructions.		1/17/17
K 781 SS=E	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be	K 781			1/17/17

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K 781	Continued From page 3 prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a written and current Space Heater Policy. This deficient practice could affect 61 of 61 residents. Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/07/2016, documentation reviewed revealed that the Facility does not have a written Space Heater Policy that is specific to Oaklawn Care & Rehab Center. This deficient practice was verified by the Facility Maintenance Director.	K 781	Fire code form was created addressing the rule of the no space heaters allowed at Oaklawn Rehabilitation Center. Form will be distributed to residents in their admissions packet upon admission. Staff will receive the form during their new employee orientation. Staff will be educated in all staff meeting regarding this policy of no space heaters allowed at Oaklawn.		
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918			1/17/17

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K 918	Continued From page 4 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This deficient practice could affect 61 of 61 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918	All future Monthly Emergency Generator Load Test will have documentation on how long it takes the emergency generator to assume power and the amount of time the generator is cooling down after the load test.		

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K 918	Continued From page 5 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/07/2016, documentation reviewed revealed that not all the required information is being documented during the Month Emergency Generator Load Test. The transfer time of how long it takes the emergency generator to assume power is not being recorded. This deficient practice was verified by the Facility Maintenance Director.	K 918			
K 920	NFPA 101 Electrical Equipment - Power Cords	K 920			1/17/17

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K 920 SS=F	Continued From page 6 and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5. This deficient practice could affect 61 of the 61 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment	K 920	Refrigerator in 201B was plugged into the wall and extension cord was removed from the room. Maintenance Director or designee will complete audit of refrigerators in rooms monthly x3 with results reported to QA committee for analysis and further recommendations.		

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K 920	Continued From page 7 (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INSCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/07/2016, observation revealed an extension cord being used as a source of fixed wiring in Resident Room 201B. A small refrigerator was plugged into a power strip by using the extension cord. This deficient practice was verified by the Facility Maintenance Director.	K 920			