



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2026

Administrator
Oaklawn Care & Rehabilitation Center
201 OAKLAWN AVENUE
MANKATO, MN 56001

RE: CCN: 245517

Cycle Start Date: June 10, 2026

Dear Administrator:

On July 6, 2026, we informed you that we may impose enforcement remedies.

On June 18, 2026, the Minnesota Department of Health 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 10, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 10, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 10, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 \$13,343, 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 September 10, 2026, 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 September 10, 2026. 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" and/or an "E"tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us

Office (507) 206-2728

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 December 10, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request

for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2026

Administrator
Oaklawn Care & Rehabilitation Center
NO DATA

Re: State Nursing Home Licensing Orders
Event ID: 236237-H1

Dear Administrator:

The above facility survey was completed on June 18, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0000	INITIAL COMMENTS On 6/17/26, and 6/18/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H55172925C (3042848) with deficiencies issued at: F756, F760, and F761. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			08/01/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d)			F0756	Please accept this Plan of Correction as the facility’s credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. How corrective action will be accomplished for those residents found to have been affected by the deficient practice R1's Haloperidol order was discontinued immediately after the error was discovered. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur		08/01/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0756 SS = D	Continued from page 1 of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the consultant pharmacist identified and reported a medication irregularity during the required monthly drug regimen review for 1 of 1 residents (R1), when an unauthorized Haloperidol order remained active despite the resident's diagnoses of epilepsy and Parkinsonism. This failure resulted in the medication remaining on the resident's medication regimen from March through June 2026 without identification during the required monthly pharmacist reviews. R1's face sheet dated 6/17/26, identified diagnoses of localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures not intractable without status epilepticus (abnormal electrical activity begins in a specific area of the brain rather than the entire brain, hallucinations, and parkinsonism (condition that affects movement). R1's Medication Administration Record (MAR) dated 3/2026, identified an order for Haloperidol Lactate oral concentration (Haldol) 2 milligrams (mg)/milliliter (mL). Give 1.5 mL by mouth at bedtime for terminal agitation. Start 3/13/26 at 7:00 p.m.			F0756	Continued from page 1 All residents have the potential to be affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur A full house audit was completed for all medication orders entered since 03/01/26 to ensure order accuracy. Any discrepancies noted were reviewed with the provider and corrected as necessary. Reviewed monthly drug regimen review process with Consultant Pharmacist and facility medication order entry process. Initiated new medication order entry process including a double check process on all new medication orders. Educated nurses, Health Information, and receptionists on new medication order entry process and facility expectations. Implemented new medication order entry audit process with facility nursing leadership. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee will complete random audits of new medication orders for order accuracy and presence of provider order to ensure compliance twice weekly x4 weeks, weekly x 1 month, monthly x1 month, and will report to QAPI committee for further review and recommendations.		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0756 SS = D	Continued from page 2 Review of R1’s record identified no corresponding physician order to begin Haloperidol Lactate between 3/2026-6/2026 had been prescribed to R1. No corresponding progress note identifying the order or that a physician prescribed it. R1's MAR's for 3/2026, 4/2026, 5/2026, and 6/2026, identified that Haldol was given every evening beginning on 3/13/26 through 6/9/26. R1’s Extended Care Visit Note dated 3/23/26, identified current orders reviewed which included Haldol 1.5 mL at bedtime. Additionally, R1 was seen by and current orders reviewed and signed which included the Haldol 1.5 mL at bedtime on 4/22/26, and 5/11/26. Hospice Current Plan of Care dated 3/26/26, did not identify a current order for Haloperidol. However, under "additional services" which was a capitulation of R1's record with hospice, it identified to discontinue all Haldol orders on 1/28/26. Additionally, the Hospice Current Plan of Care completed on 4/23/26, 5/7/26, 5/21/26, and 6/4/26, did not identify the order for Haldol that began on 3/13/26. R1’s pharmacy recommendations dated 5/20/26, identified a recommendation that Haloperidol 2mg/mL (1.5 mL) is currently ordered nightly for agitation. Consider changing the order to as needed and discontinue if not used. During a return telephone interview on 6/24/26 at 9:16 a.m., consultant pharmacist (CP)-A stated she reviewed all current residents' medications once a month. CP-A stated she reviewed each resident's current medication list and certain medications should be monitored more closely, including psychotropics, medications requiring laboratory monitoring, and as needed antipsychotics. CP-A stated she reviewed her April recommendations for R1 and did not make any notes regarding Haldol and was uncertain why she did not. CP-A acknowledged she made a recommendation in May to change the medication to as needed and discontinue. During a telephone interview on 6/18/26 at 11:56			F0756			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0756 SS = D	Continued from page 3 a.m., pharmacist (Ph)-B stated monthly drug regimen reviews are completed by the consultant pharmacist. Ph-B stated if she had completed the April review, she may have flagged the Haldol because of the resident's Parkinsonism and epilepsy. Ph-B stated antipsychotics are warned against for patients with Parkinsonism and epilepsy and if this represented a starting dose for Haldol it would be considered high for someone naïve to the medication or who had been off the medication for some time. The pharmacy Consultant Pharmacist Services Provider Requirements dated 5/2022 identified regular and reliable consultant pharmacist services are provided to residents. The consultant pharmacist is responsible for identifying and evaluating medication-related issues, including prevention and reporting of medication errors, identifying contraindications, side effects and adverse effects, completing a monthly medication regimen review, communicating potential or actual medication-related problems to the responsible prescriber and facility leadership, reviewing medication administration records and physician orders at least monthly, and documenting resident-specific recommendations in the resident's active record.			F0756			08/01/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 1 residents (R1) was free from a significant medication error when Haloperidol was entered into the facility's integrated electronic medication ordering system and administered to R1 from 3/13/26 through 6/9/26 without a valid and verified physician order. Findings include: The Nursing Home Incident Report (NHIR) submitted to the State Agency (SA) identified Haloperidol order intended for another resident was inadvertently entered into R1's chart. Medication was administered until review following seizure activity and discontinued upon discovery.			F0760	Please accept this Plan of Correction as the facility's credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. How corrective action will be accomplished for those residents found to have been affected by the deficient practice R1's Haloperidol order was discontinued immediately after the error was discovered. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur All residents have the potential to be affected. What measures will be put into place or systematic		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0760 SS = D	Continued from page 4 R1’s face sheet dated 6/17/26, identified diagnoses of localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures not intractable without status epilepticus (abnormal electrical activity begins in a specific area of the brain rather than the entire brain, hallucinations, and parkinsonism (condition that affects movement). R1’s quarterly Minimum Data Set (MDS) dated 3/24/26, identified R1 had severe memory issues, no hearing issues and wore glasses, required some assistance with activities of daily living. R1 was taking antipsychotic medication on a regular basis with no gradual dose reduction attempted. R1’s care plan dated 6/17/26 identified R1 had a seizure disorder with diagnosis of localization related symptomatic epilepsy with complex partial seizures and recent seizure activity. Interventions included: ensure a position to prevent injury during seizure activity, ensure open airway and document characteristics of seizure; monitor neurological status after any activity for residual impairment; notify medical doctor (MD) of any seizure activity; provide privacy and dignity during seizure activity; seizure medication management by hospice provider with scheduled and as needed Lorazepam; seizure medications will be administered as ordered, monitor for effect and side effects. R1’s Pharmacist Recommendation dated 3/11/26, identified a pharmacy recommendation for Lorazepam. Handwritten note of prescribers response “patient with high-risk seizure disorder-needs to have” and signed by MD-A. R1’s Medication Administration Record (MAR) dated 3/2026, identified an order for Haloperidol Lactate oral concentration (Haldol) 2 milligrams (mg)/milliliter (mL). Give 1.5 mL by mouth at bedtime for agitation. Start 3/13/26 at 7:00 p.m. with a discontinued date of 3/13/26 at 12:20 p.m. A second order Haloperidol Lactate oral concentration 2 mg/mL. Give 1.5 mL by mouth at bedtime for terminal agitation. Start 3/13/26 at 7:00 p.m. Review of R1’s record identified no corresponding physician order to begin Haloperidol Lactate between 3/2026-6/2026 had been prescribed to R1. No corresponding progress note identifying the order or that a physician prescribed it. Review of R1’s MAR’s for 3/2026, 4/2026, 5/2026, and 6/2026, identified R1 was administered Haldol every evening from 3/13/26-6/9/26.			F0760	Continued from page 4 changes made to ensure that the deficient practice will not recur A full house audit was completed for all medication orders entered since 03/01/26 to ensure order accuracy. Any discrepancies noted were reviewed with the provider and corrected as necessary. Reviewed monthly drug regimen review process with Consultant Pharmacist, medication reconciliation process with Ecumen Hospice nurse, and facility medication order entry process. Initiated new medication order entry process including a double check process on all new medication orders. Educated nurses, Health Information, and receptionists on new medication order entry process and facility expectations. Implemented new medication order entry audit process with facility nursing leadership. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee will complete random audits of new medication orders for order accuracy and presence of provider order to ensure compliance twice weekly x4 weeks, weekly x 1 month, monthly x1 month, and will report to QAPI committee for further review and recommendations.		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0760 SS = D	Continued from page 5 During a telephone interview on 6/17/26 at 11:36 a.m., licensed practical nurse (LPN)-A stated on 3/12/26, she recalled going through orders for R1 and thought she took the Haldol order out of the system and put it back in the system. LPN-A recalled it was a hospice order. While transcribing it, she had gotten up from the computer and went to the medication cart to verify the strength. R1 still had a bottle of Haldol in the medication drawer from a prior order. LPN-A had not been aware that orders put in the electronic record go straight to the pharmacy to be filled. LPN-A could not recall if there was an order for a different resident and she transcribed it in R1’s chart or how she ended up putting the order in R1’s electronic record. During a telephone interview on 6/17/26 at 11:30 a.m., pharmacy technician (PhT)-A stated the facility was integrated with the pharmacy to directly fill the orders that were transcribed into the electronic health record. If the order was in the system, the facility did not have to send the pharmacy confirmation of order with a doctor signature. There was no way for pharmacy to verify the order written was correct. When the order was written in the electronic system a provider name had to be attached to the order. PhT-A was aware the electronic system allowed for any provider name to be attached to the order. R1’s Extended Care Visit Note dated 3/23/26, identified current orders reviewed which included Haldol 1.5 mL at bedtime. Additionally, R1 was seen by and current orders reviewed and signed which included the Haldol 1.5 mL at bedtime on 4/22/26, and 5/11/26. Hospice Current Plan of Care dated 3/26/26, did not identify a current order for Haloperidol. However, under “additional services” which was a capitulation of R1’s record with hospice, it identified to discontinue all Haldol orders on 1/28/26. Additionally, the Hospice Current Plan of Cares completed on 4/23/26, 5/7/26, 5/21/26, and 6/4/26, did not identify the order for Haldol that began 3/13/26. R1’s progress note dated 4/22/26, identified R1 had an episode with full body tremors, stiffness in legs, arms, and hands accompanied by a blank stare. R1’s pharmacy recommendations dated 5/20/26, identified a recommendation that Haloperidol 2mg/mL (1.5 mL) is currently ordered nightly for agitation. Consider changing the order to as needed			F0760			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0760 SS = D	Continued from page 6 and discontinue if not used. During a telephone interview on 6/18/26 at 11:56 a.m., pharmacist (Ph)-B stated drug regimen reviews are completed monthly on all residents by the consultant pharmacist (CP)-A. Ph-B stated if she had done the review in April she may have flagged the Haldol for Parkinsons and epilepsy but if the patient was doing well and did not have seizures or worsening motor issues she may not have flagged the medication. Ph-B stated antipsychotics are warned against for patients with Parkinsons and epilepsy. If that was a starting dose for Haldol, it would be considered high for someone that was naïve to the medication or had been off of it for awhile. During a return telephone interview on 6/24/26 at 9:16 a.m., from a call on 6/18/26 at 11:26 a.m. when consultant pharmacist (CP)-A was not near a computer stated she reviewed all current residents medications once a month that are at the facility. CP-A would look at residents current medication list. Certain medications should be monitored more such as psychotropics, medications that require lab monitoring, and as needed antipsychotics. CP-A reviewed her recommendations for R1 in April and stated she did not make any notes about Haldol and was uncertain why she did not but did make a note on the May recommendation to change to as needed and discontinue. R1’s Extended Care Visit Note dated 6/8/26, identified to discuss with hospice regarding Haldol use at bedtime to see if this could be tapered to 1 mL since there are no recent reports of agitation at bedtime. R1’s record identified on 6/8/26, the pharmacy recommendation was reviewed by nurse practitioner (NP)-A with recommendation to discuss with hospice because hospice prescribed this medication. R1’s progress note dated 6/9/26, identified at noon R1 was observed having a seizure. During seizure, R1 was gasping for air with very loud (snore-like) breathing. Following the seizure, R1 was very tired. R1’s physician order dated 6/9/26, identified discontinue Haldol. During an interview on 6/17/26 at 8:42 a.m., registered nurse (RN)-A stated R1 had recently had three seizures. RN-A stated R1 had two seizures during the night on 6/9/26, and then the one at noon that she charted about. RN-A stated the			F0760			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0760 SS = D	Continued from page 7 seizure lasted approximately five minutes after she was in the room with R1. R1 had a hard time coming out of the seizure. Reviewed R1’s Haldol order from 3/13/26, RN-A stated it was put in the system by LPN-A. RN-A could not locate an order that had been prescribed by a physician for the Haldol in the computer. RN-A was unsure how the bottle of Haldol could have come from the pharmacy without an actual order for it. During an interview on 6/17/26 at 3:46 p.m., nurse managers (NM)-A and B stated they were unaware that facility was integrated with pharmacy and that pharmacy could fill orders based off the order put in the system without a physical copy sent to them. During an interview on 6/17/26 at 9:06 a.m., Administrator stated regional nurse consultant (RNC)-A completed the investigation of the incident and believed the medication was intended for R2. During an interview on 6/17/26 at 9:18 a.m., RNC-A stated R2 had an order to discontinue Haldol when Ativan arrived and LPN-A had put that order in about the same time the order for R1 was written. The pharmacy is integrated with the electronic record and when an order is put in electronically the order is automatically transmitted to the pharmacy. Pharmacy can fill the order and send to facility without an actual physical order present unless it is a controlled drug, Intravenous medication, new admissions, hospital returns, or if the number of characters is too big in the order we put in. The facility had a safeguard in place for when the Health Unit Coordinator (HUC) placed orders in the electronic record that required a nurse to verify the order was correct prior to the order being live in the system. Medical doctor (MD)-A discontinued the Haldol for R1 because it lowers the seizure threshold. At 11:20 a.m., RNC-A stated pharmacy recommendations are reviewed on routine rounds with clinics on resident scheduled visits unless it was an urgent recommendation that needed to be addressed immediately. During an interview on 6/18/26 at 12:40 p.m., RNC-A stated facility, primary care providers, and hospice should be reviewing the residents charts to ensure accuracy. During a telephone interview on 6/18/26 at 11:06 a.m., hospice clinical director (CD)-A stated hospice should complete a medication reconciliation upon admission, every six months, and with medication changes hospice initiated. Routinely, and at a minimum every couple of weeks, hospice nurse			F0760			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0760 SS = D	Continued from page 8 should compare medication list with facility medication list to make sure they match. CD-A reviewed hospice records for R1. Hospice did not have any notes about medication reconciliation being completed in March, April, or May. In June, there was a note that facility was completing an internal investigation on Haldol medication that had been given to R1 since March. Knowledge and training of RN's and physicians should be that we check for Parkinsonism and history of seizures in patients. During a telephone interview on 6/17/26 at 3:09 p.m., pharmacist (Ph)-A stated Haldol 1.5 mL was three time the normal starting dose. Ph-A stated if R1 already had a history of seizures she could not say if this error would cause more seizures necessarily. Ph-A stated that based on the dose this would be considered a significant medication error. During a telephone interview on 6/18/26 at 9:36 a.m., medical doctor (MD)-A stated she discontinued the Haldol because it was not an appropriate medication for R1's diagnoses. During a telephone interview on 6/17/26 at 3:18 p.m., MD-A stated R1 had seizures and every time a person has a seizure there is neurological harm. Haldol is not advised in patients with seizure disorder as it lowers the seizure threshold or Parkinsons. Seizures/Parkinsonism could cause a lot of freezing with muscle issues. MD-A could not say with 100% certainty that R1's Haldol usage caused the seizure but "the fact that we put him at any risk is not good". "I just feel like he kind of got double whammied with the whole thing". MD-A was frustrated because the facility put the order under her name and she "absolutely did not give the order". The facility Medication and Treatment Orders policy dated 2/2024, identified orders must be recorded on th Physicians Order Sheet in the residents chart. Such orders are reviewed by the consultant pharmacist. Orders for medications will be transcribed in a timely manner. The pharmacy Consultant Pharmacist Services Provider Requirements dated 5/2022, identified regular and reliable consultant pharmacist services are provided to residents. Assists with identification and evaluation of medication-related issues, including prevention and reporting of medication errors. Identifying one or more current medication references to facilitate the identification of medications and information on contraindications,			F0760			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0760 SS = D	Continued from page 9 side effects and/or adverse effects. Completing a monthly medication regimen review, communicating to responsible prescriber and facility leadership potential or actual problems detected and other findings related to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well a regulatory compliance issues. Reviewing medication administration records and physician orders at least monthly to ensure proper documentation of medication orders and administration to residents. Resident specific recommendations are documented in the residents active record. The facility Hospice policy dated 11/2023, identified it is the responsibility of the hospice agency to coordinate residents care as it relates to terminal illness and related conditions. It is the responsibility of facility staff to notify the hospice provider and primary care provider about significant change in condition or situations requiring a revision of the plan of care. The Physician Visits policy dated 8/2024, identified the attending physician must perform relevant tasks at the time of each visit, including a review of the residents total program of care and appropriate documentation.			F0760			08/01/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of			F0761	Please accept this Plan of Correction as the facility’s credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. How corrective action will be accomplished for those residents found to have been affected by the deficient practice R3 and R4's discontinued medications were immediately removed from the medication cart when identified by the surveyor. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur All residents have the potential to be affected.		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0761 SS = D	Continued from page 10 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: Based on observation, interview, and record review the facility failed to remove discontinued medications from the active medication storage for 2 of 2 residents (R3, R4) creating the potential for inadvertent medication administration. Findings include: R3 During an observation and interview on 6/17/26 at 12:36 p.m., Registered nurse (RN)-A opened the medication cart and went to R3's medication section. RN-A observed R3's Lidocaine patches and Quetiapine Fumarate (Seroquel) remained in the medication cart. RN-A reviewed R3's current medication orders and stated there was not a current order for Seroquel or Lidocaine patches. RN-A removed the medications from the medication cart and stated medications should be removed from the medication cart right away after the order was discontinued to avoid medication errors. RN-A stated it was basic nursing knowledge to remove discontinued medications from the medication cart. R3's face sheet dated 6/17/26, identified diagnoses of fracture of one right rib, other chronic pain, agoraphobia with panic disorder, and generalized anxiety disorder. R3's physician visit dated 6/8/26, identified an order to discontinue Quetiapine Fumarate (Seroquel) 25 milligram (mg) oral tablet. R3's progress note dated 6/8/26, identified nurse practitioner (NP) visited resident today with new orders given. NP would follow-up in one week. R3's physician visit dated 6/15/26, identified an order to discontinue lidocaine 4% external patch and the same order to discontinue Quetiapine Fumarate 25 mg as ordered on 6/8/26. R3's progress note dated 6/16/26, identified R3 was seen on rounds by NP. Orders to discontinue lidocaine patch for non-use, and discontinue			F0761	Continued from page 10 What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur A full house audit was completed to ensure discontinued medications were removed from the medication carts. Reviewed the Polaris Discontinued Medications policy. Educated nurses on the Polaris Discontinued Medications policy, facility process, and expectations. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee will complete random audits of medication carts and discontinued medications to ensure compliance weekly x4 weeks, monthly x2 months, and will report to QAPI committee for further review and recommendations.		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0761 SS = D	Continued from page 11 Seroquel. R3’s medication administration record (MAR) dated 6/2026, identified Quetiapine Fumarate was administered daily from 6/1/26-6/15/26. The Lidocaine patch was marked as “2”-drug refused from 6/1/26-6/15/26. During an interview on 6/17/26 at 1:03 p.m., RN-B stated she reviewed physician dictation on 6/16/26, while working the night shift. RN-B stated she would remove the order from the electronic medical record, enter a progress note, and then remove the discontinued medication from the medication cart. RN-B stated she forgot to remove the medications after discontinuing the orders in the electronic system. R4 During the observation and interview on 6/17/26 at 12:36 p.m., RN-A opened the medication cart and went to R4's medication section. RN-A observed Amlodipine remained in the medication cart after the medication had been discontinued. RN-A removed the medication from the medication cart. R4’s face sheet dated 6/17/26, identified a diagnosis of essential (primary) hypertension. R4’s progress note date 6/15/26, identified R4 was seen by physician on 6/11/26. Orders to discontinue Amlodipine 5 mg received. R4’s MAR dated 6/2026, identified Amlodipine Besylate 5mg was provided to R4 from 6/1/26-6/15/26. During an interview nurse manager (NM)-B stated after discontinuing a medication it should be removed from the medication cart. NM-B would occasionally go through the medication carts and remove ones she was aware had been discontinued. Nurses are expected to pull discontinued medications when the order is discontinued. During an interview on 6/18/26 at 12:40 p.m., regional nurse consultant (RNC)-A stated she expected medications that were discontinued to be removed from the medication cart within a reasonable amount of time between five minutes to one hour after discontinuing the order. Not doing that could lead to potential medications errors and inadvertent administration. During a telephone interview on 6/18/26 at 9:36			F0761			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0761 SS = D	Continued from page 12 a.m., medical doctor (MD)-A stated she expected the facility to review the entire dictation when it was sent to them so they are aware of all order changes. The facility Discontinuation of Medications policy dated 5/2022, identified medication are removed from the medication cart or active supply immediately upon receipt of an order to discontinue to avoid inadvertent administration.			F0761			08/01/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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	
20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/17/26, and 6/18/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued: 21545 and 21550. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H55172925C (3042848) with a licensing orders issued at: 1530 and 1545.		20000			08/01/2026	

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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	
20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.		20000			08/01/2026	
21530	Drug Regimen Review CFR(s): MN Rule 4658.1310 A.B.C A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is		21530	Corrected		08/01/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21530	Continued from page 2 incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the consultant pharmacist identified and reported a medication irregularity during the required monthly drug regimen review for 1 of 1 residents (R1), when an unauthorized Haloperidol order remained active despite the resident's diagnoses of epilepsy and Parkinsonism. This failure resulted in the medication remaining on the resident's medication regimen from March through June 2026 without identification during the required monthly pharmacist reviews. Findings include R1's face sheet dated 6/17/26, identified diagnoses of localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures not intractable without status epilepticus (abnormal electrical activity begins in a specific area of the brain rather than the entire brain, hallucinations, and parkinsonism (condition that affects movement). R1's Medication Administration Record (MAR) dated			21530			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21530	Continued from page 3 3/2026, identified an order for Haloperidol Lactate oral concentration (Haldol) 2 milligrams (mg)/milliliter (mL). Give 1.5 mL by mouth at bedtime for terminal agitation. Start 3/13/26 at 7:00 p.m. Review of R1's record identified no corresponding physician order to begin Haloperidol Lactate between 3/2026-6/2026 had been prescribed to R1. No corresponding progress note identifying the order or that a physician prescribed it. R1's MAR's for 3/2026, 4/2026, 5/2026, and 6/2026, identified that Haldol was given every evening beginning on 3/13/26 through 6/9/26. R1's Extended Care Visit Note dated 3/23/26, identified current orders reviewed which included Haldol 1.5 mL at bedtime. Additionally, R1 was seen by and current orders reviewed and signed which included the Haldol 1.5 mL at bedtime on 4/22/26, and 5/11/26. Hospice Current Plan of Care dated 3/26/26, did not identify a current order for Haloperidol. However, under "additional services" which was a capitulation of R1's record with hospice, it identified to discontinue all Haldol orders on 1/28/26. Additionally, the Hospice Current Plan of Care completed on 4/23/26, 5/7/26, 5/21/26, and 6/4/26, did not identify the order for Haldol that began on 3/13/26. R1's pharmacy recommendations dated 5/20/26, identified a recommendation that Haloperidol 2mg/mL (1.5 mL) is currently ordered nightly for agitation. Consider changing the order to as needed and discontinue if not used. During a return telephone interview on 6/24/26 at 9:16 a.m., consultant pharmacist (CP)-A stated she reviewed all current residents' medications once a month. CP-A stated she reviewed each resident's current medication list and certain medications should be monitored more closely, including psychotropics, medications requiring laboratory monitoring, and as needed antipsychotics. CP-A stated she reviewed her April recommendations for R1 and did not make any notes regarding Haldol and was uncertain why she did not. CP-A acknowledged she made a recommendation in May to change the medication to as needed and discontinue. During a telephone interview on 6/18/26 at 11:56 a.m., pharmacist (Ph)-B stated monthly drug regimen reviews are completed by the consultant pharmacist. Ph-B stated if she had completed the April review,			21530			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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	
21530	Continued from page 4 she may have flagged the Haldol because of the resident's Parkinsonism and epilepsy. Ph-B stated antipsychotics are warned against for patients with Parkinsonism and epilepsy and if this represented a starting dose for Haldol it would be considered high for someone naïve to the medication or who had been off the medication for some time. The pharmacy Consultant Pharmacist Services Provider Requirements dated 5/2022 identified regular and reliable consultant pharmacist services are provided to residents. The consultant pharmacist is responsible for identifying and evaluating medication-related issues, including prevention and reporting of medication errors, identifying contraindications, side effects and adverse effects, completing a monthly medication regimen review, communicating potential or actual medication-related problems to the responsible prescriber and facility leadership, reviewing medication administration records and physician orders at least monthly, and documenting resident-specific recommendations in the resident's active record. Suggested Method of Correction: The DON/designee could review applicable pharmacy policies, provide education to staff, go through the medication carts removing any discontinued or expired medications. The facility could then develop an ongoing auditing system to ensure ongoing compliance. Time Period of correction: twenty-one (21) days.		21530			08/01/2026	
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is:		21545	Corrected		08/01/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21545	Continued from page 5 (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 1 residents (R1) was free from a significant medication error when Haloperidol was entered into the facility's integrated electronic medication ordering system and administered to R1 from 3/13/26 through 6/9/26 without a valid and verified physician order. Findings include: The Nursing Home Incident Report (NHIR) submitted to the State Agency (SA) identified Haloperidol order intended for another resident was inadvertently entered into R1's chart. Medication was administered until review following seizure activity and discontinued upon discovery. R1's face sheet dated 6/17/26, identified diagnoses of localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures not intractable without status epilepticus (abnormal electrical activity begins in a specific area of the brain rather than the entire brain, hallucinations, and parkinsonism (condition that			21545			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21545	Continued from page 6 affects movement). R1’s quarterly Minimum Data Set (MDS) dated 3/24/26, identified R1 had severe memory issues, no hearing issues and wore glasses, required some assistance with activities of daily living. R1 was taking antipsychotic medication on a regular basis with no gradual dose reduction attempted. R1’s care plan dated 6/17/26 identified R1 had a seizure disorder with diagnosis of localization related symptomatic epilepsy with complex partial seizures and recent seizure activity. Interventions included: ensure a position to prevent injury during seizure activity, ensure open airway and document characteristics of seizure; monitor neurological status after any activity for residual impairment; notify medical doctor (MD) of any seizure activity; provide privacy and dignity during seizure activity; seizure medication management by hospice provider with scheduled and as needed Lorazepam; seizure medications will be administered as ordered, monitor for effect and side effects. R1’s Pharmacist Recommendation dated 3/11/26, identified a pharmacy recommendation for Lorazepam. Handwritten note of prescribers response “patient with high-risk seizure disorder-needs to have” and signed by MD-A. R1’s Medication Administration Record (MAR) dated 3/2026, identified an order for Haloperidol Lactate oral concentration (Haldol) 2 milligrams (mg)/milliliter (mL). Give 1.5 mL by mouth at bedtime for agitation. Start 3/13/26 at 7:00 p.m. with a discontinued date of 3/13/26 at 12:20 p.m. A second order Haloperidol Lactate oral concentration 2 mg/mL. Give 1.5 mL by mouth at bedtime for terminal agitation. Start 3/13/26 at 7:00 p.m. Review of R1’s record identified no corresponding physician order to begin Haloperidol Lactate between 3/2026-6/2026 had been prescribed to R1. No corresponding progress note identifying the order or that a physician prescribed it. Review of R1’s MAR’s for 3/2026, 4/2026, 5/2026, and 6/2026, identified R1 was administered Haldol every evening from 3/13/26-6/9/26. During a telephone interview on 6/17/26 at 11:36 a.m., licensed practical nurse (LPN)-A stated on 3/12/26, she recalled going through orders for R1 and thought she took the Haldol order out of the system and put it back in the system. LPN-A recalled it was a hospice order. While transcribing it,			21545			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21545	Continued from page 7 she had gotten up from the computer and went to the medication cart to verify the strength. R1 still had a bottle of Haldol in the medication drawer from a prior order. LPN-A had not been aware that orders put in the electronic record go straight to the pharmacy to be filled. LPN-A could not recall if there was an order for a different resident and she transcribed it in R1’s chart or how she ended up putting the order in R1’s electronic record. During a telephone interview on 6/17/26 at 11:30 a.m., pharmacy technician (PhT)-A stated the facility was integrated with the pharmacy to directly fill the orders that were transcribed into the electronic health record. If the order was in the system, the facility did not have to send the pharmacy confirmation of order with a doctor signature. There was no way for pharmacy to verify the order written was correct. When the order was written in the electronic system a provider name had to be attached to the order. PhT-A was aware the electronic system allowed for any provider name to be attached to the order. R1’s Extended Care Visit Note dated 3/23/26, identified current orders reviewed which included Haldol 1.5 mL at bedtime. Additionally, R1 was seen by and current orders reviewed and signed which included the Haldol 1.5 mL at bedtime on 4/22/26, and 5/11/26. Hospice Current Plan of Care dated 3/26/26, did not identify a current order for Haloperidol. However, under “additional services” which was a capitulation of R1’s record with hospice, it identified to discontinue all Haldol orders on 1/28/26. Additionally, the Hospice Current Plan of Cares completed on 4/23/26, 5/7/26, 5/21/26, and 6/4/26, did not identify the order for Haldol that began 3/13/26. R1’s progress note dated 4/22/26, identified R1 had an episode with full body tremors, stiffness in legs, arms, and hands accompanied by a blank stare. R1’s pharmacy recommendations dated 5/20/26, identified a recommendation that Haloperidol 2mg/mL (1.5 mL) is currently ordered nightly for agitation. Consider changing the order to as needed and discontinue if not used. During a telephone interview on 6/18/26 at 11:56 a.m., pharmacist (Ph)-B stated drug regimen reviews are completed monthly on all residents by the consultant pharmacist (CP)-A. Ph-B stated if she had done the review in April she may have flagged			21545			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21545	Continued from page 8 the Haldol for Parkinsons and epilepsy but if the patient was doing well and did not have seizures or worsening motor issues she may not have flagged the medication. Ph-B stated antipsychotics are warned against for patients with Parkinsons and epilepsy. If that was a starting dose for Haldol, it would be considered high for someone that was naïve to the medication or had been off of it for awhile. During a return telephone interview on 6/24/26 at 9:16 a.m., from a call on 6/18/26 at 11:26 a.m. when consultant pharmacist (CP)-A was not near a computer stated she reviewed all current residents medications once a month that are at the facility. CP-A would look at residents current medication list. Certain medications should be monitored more such as psychotropics, medications that require lab monitoring, and as needed antipsychotics. CP-A reviewed her recommendations for R1 in April and stated she did not make any notes about Haldol and was uncertain why she did not but did make a note on the May recommendation to change to as needed and discontinue. R1’s Extended Care Visit Note dated 6/8/26, identified to discuss with hospice regarding Haldol use at bedtime to see if this could be tapered to 1 mL since there are no recent reports of agitation at bedtime. R1’s record identified on 6/8/26, the pharmacy recommendation was reviewed by nurse practitioner (NP)-A with recommendation to discuss with hospice because hospice prescribed this medication. R1’s progress note dated 6/9/26, identified at noon R1 was observed having a seizure. During seizure, R1 was gasping for air with very loud (snore-like) breathing. Following the seizure, R1 was very tired. R1’s physician order dated 6/9/26, identified discontinue Haldol. During an interview on 6/17/26 at 8:42 a.m., registered nurse (RN)-A stated R1 had recently had three seizures. RN-A stated R1 had two seizures during the night on 6/9/26, and then the one at noon that she charted about. RN-A stated the seizure lasted approximately five minutes after she was in the room with R1. R1 had a hard time coming out of the seizure. Reviewed R1’s Haldol order from 3/13/26, RN-A stated it was put in the system by LPN-A. RN-A could not locate an order that had been prescribed by a physician for the Haldol in the computer. RN-A was unsure how the bottle of			21545			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21545	Continued from page 9 Haldol could have come from the pharmacy without an actual order for it. During an interview on 6/17/26 at 3:46 p.m., nurse managers (NM)-A and B stated they were unaware that facility was integrated with pharmacy and that pharmacy could fill orders based off the order put in the system without a physical copy sent to them. During an interview on 6/17/26 at 9:06 a.m., Administrator stated regional nurse consultant (RNC)-A completed the investigation of the incident and believed the medication was intended for R2. During an interview on 6/17/26 at 9:18 a.m., RNC-A stated R2 had an order to discontinue Haldol when Ativan arrived and LPN-A had put that order in about the same time the order for R1 was written. The pharmacy is integrated with the electronic record and when an order is put in electronically the order is automatically transmitted to the pharmacy. Pharmacy can fill the order and send to facility without an actual physical order present unless it is a controlled drug, Intravenous medication, new admissions, hospital returns, or if the number of characters is too big in the order we put in. The facility had a safeguard in place for when the Health Unit Coordinator (HUC) placed orders in the electronic record that required a nurse to verify the order was correct prior to the order being live in the system. Medical doctor (MD)-A discontinued the Haldol for R1 because it lowers the seizure threshold. At 11:20 a.m., RNC-A stated pharmacy recommendations are reviewed on routine rounds with clinics on resident scheduled visits unless it was an urgent recommendation that needed to be addressed immediately. During an interview on 6/18/26 at 12:40 p.m., RNC-A stated facility, primary care providers, and hospice should be reviewing the residents charts to ensure accuracy. During a telephone interview on 6/18/26 at 11:06 a.m., hospice clinical director (CD)-A stated hospice should complete a medication reconciliation upon admission, every six months, and with medication changes hospice initiated. Routinely, and at a minimum every couple of weeks, hospice nurse should compare medication list with facility medication list to make sure they match. CD-A reviewed hospice records for R1. Hospice did not have any notes about medication reconciliation being completed in March, April, or May. In June, there was a note that facility was completing an internal investigation on Haldol medication that had			21545			08/01/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21545	Continued from page 10 been given to R1 since March. Knowledge and training of RN's and physicians should be that we check for Parkinsonism and history of seizures in patients. During a telephone interview on 6/17/26 at 3:09 p.m., pharmacist (Ph)-A stated Haldol 1.5 mL was three time the normal starting dose. Ph-A stated if R1 already had a history of seizures she could not say if this error would cause more seizures necessarily. Ph-A stated that based on the dose this would be considered a significant medication error. During a telephone interview on 6/18/26 at 9:36 a.m., medical doctor (MD)-A stated she discontinued the Haldol because it was not an appropriate medication for R1's diagnoses. During a telephone interview on 6/17/26 at 3:18 p.m., MD-A stated R1 had seizures and every time a person has a seizure there is neurological harm. Haldol is not advised in patients with seizure disorder as it lowers the seizure threshold or Parkinsons. Seizures/Parkinsonism could cause a lot of freezing with muscle issues. MD-A could not say with 100% certainty that R1's Haldol usage caused the seizure but "the fact that we put him at any risk is not good". "I just feel like he kind of got double whammied with the whole thing". MD-A was frustrated because the facility put the order under her name and she "absolutely did not give the order". The facility Medication and Treatment Orders policy dated 2/2024, identified orders must be recorded on th Physicians Order Sheet in the residents chart. Such orders are reviewed by the consultant pharmacist. Orders for medications will be transcribed in a timely manner. The pharmacy Consultant Pharmacist Services Provider Requirements dated 5/2022, identified regular and reliable consultant pharmacist services are provided to residents. Assists with identification and evaluation of medication-related issues, including prevention and reporting of medication errors. Identifying one or more current medication references to facilitate the identification of medications and information on contraindications, side effects and/or adverse effects. Completing a monthly medication regimen review, communicating to responsible prescriber and facility leadership potential or actual problems detected and other findings related to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication			21545			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
21545	Continued from page 11 therapy as well a regulatory compliance issues. Reviewing medication administration records and physician orders at least monthly to ensure proper documentation of medication orders and administration to residents. Resident specific recommendations are documented in the residents active record. The facility Hospice policy dated 11/2023, identified it is the responsibility of the hospice agency to coordinate residents care as it relates to terminal illness and related conditions. It is the responsibility of facility staff to notify the hospice provider and primary care provider about significant change in condition or situations requiring a revision of the plan of care. The Physician Visits policy dated 8/2024, identified the attending physician must perform relevant tasks at the time of each visit, including a review of the residents total program of care and appropriate documentation. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures transcribing medication, and order validation with licensed staff. The facility should develop a system to ensure prescriptions are verified with a verbal or written order from the physician. The facility should consult with the pharmacy and prescribers to assist in resolution. The facility could also develop a double check system for licensed staff transcribing order into the EHR. The facility then could educate staff on the protocols and develop an auditing system to maintain compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.			21545			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0000	INITIAL COMMENTS A Complaint Comparative Federal Monitoring Survey (FMS) was conducted at Oaklawn Care & Rehabilitation Center on July 14 through July 15, 2026. The census was 54. MN Incident 3042848 was investigated, and the facility was found to be not in compliance. The following deficiencies resulted in the facility's non-compliance: F605 at current non-compliance F760 at past non-compliance			F0000			08/01/2026
F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical			F0605	Please accept this plan of correction as the facility is credible allegation of compliance. Preparation, submission, and/or execution of this plan should not be construed as the facility admitting or agreeing to any of the findings or conclusions set forth in the corresponding CMS-2567. How corrective action will be accomplished for those residents found to have been affected by the deficient practice R1's Haloperidol order was discontinued immediately after the error was discovered. A full review of R1's medication orders was completed and verified that no other unnecessary psychotropic medications were discovered. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur All residents have the potential to be affected. Initiated new medication order entry process including a double check process on all new medication orders. This ensures that residents are free from erroneously entered, unnecessary psychotropic medications.		08/01/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0605 SS = E	Continued from page 1 symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless			F0605	Continued from page 1 What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur A full house audit was completed for all medication orders entered since 03/01/26 to ensure order accuracy. Verified that all current medication orders are prescribed medications with the correct orders in place. Reviewed monthly drug regimen review process with Consultant Pharmacist and facility medication order entry process. Educated nurses, Health Information, and receptionists on new medication order entry process and facility expectations. Implemented new medication order entry audit process with facility nursing leadership. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee will complete random audits to ensure compliance twice weekly x4 weeks, weekly x 1 month, monthly x1 month, and will report to QAPI committee for further review and recommendations.		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0605 SS = E	Continued from page 2 the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, medical record, facility policy and Food and Drug Administration medication label reviews, the facility failed to ensure one resident (R 1) was free from unnecessary psychotropic medication of four residents reviewed for psychotropic medications. Findings include: Review of the facility's Psychotropic Medication Use Policy with the last revision date of 5/2025 revealed, "...Residents will not receive psychotropic medications unless behavioral programming and/or environmental changes or other non-pharmacological interventions have failed to sufficiently address the resident's target behavioral goals..."			F0605			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0605 SS = E	Continued from page 3 According to the Food and Drug Administration (FDA) label for Haloperidol (antipsychotic medication) Oral Solution, "...Haloperidol Oral Solution is indicated for use in the management of manifestations of psychotic disorders...Haloperidol should be administered cautiously to patients...with a history of seizures...because haloperidol may lower the convulsive threshold..." Review of R 1's electronic health record (EHR) revealed diagnoses which included generalized anxiety disorder and symptomatic epilepsy (chronic neurological disorder characterized by recurrent, unprovoked seizures) and epileptic syndromes with complex partial seizures. Furthermore, R 1 was admitted to hospice on 11/20/25. Review of R 1's physician's orders from December 2025 until June 2026 revealed that R 1 had orders for, "Haloperidol Lactate Oral Concentrate 2 mg [milligrams]/ml [milliliter]...Give 0.25 ml [0.5 mg] by mouth three times a day for agitation" and "Haloperidol Lactate Oral Concentrate 2 mg/ml...Give 0.25 ml by mouth every 2 hours as needed for agitation" both with the original start date of 12/23/25. Both orders for Haloperidol were revised on 1/2/26 to change the indication from agitation to hallucinations and psychosis. Further review of R 1's physician's orders from December 2025 until June 2026 revealed an order dated 1/28/26 which indicated, "...Discontinue all Haldol [Haloperidol] orders..." Review of R 1's Medication Administration Record (MAR) for the months of March 2026 until June 2026 revealed that R 1 had received Haloperidol Lactate Oral Concentrate 2 MG/ML 1.5 ml (3 mg) by mouth at bedtime for terminal agitation from 3/13/26 until 6/9/26. Further review of R 1's EHR revealed that there were no telephone or verbal physician orders and related documentation in R 1's Progress Notes that indicated the resumption of Haloperidol for R 1. In an interview with the Licensed Practical Nurse (LPN) 1 on 7/14/26 at 2:26 PM, when asked about R 1's Haloperidol order, LPN 1 stated, "It was three months ago, I thought I took the order out. [R 1] still has medications in the medication cart, so I put the order back in. I thought I accidentally discontinued it, so I put it back in." LPN 1 further stated, "They			F0605			08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0605 SS = E	Continued from page 4 said I might have mistaken it for another resident's medication order. The hospice doctor discontinued [R 1's] Haldol." In a concurrent interview with the Regional Nurse Consultant (RNC) and the Director of Nursing (DON) on 7/15/26 at 10:33 AM, when asked about R 1's Haloperidol order, the RNC stated, "[Name of the DON] updated the facility's/hospice's medical director of the incident and the medical director called back [name of the DON] and stated that she did not have an order for it. [Name of the hospice company] discontinued Haldol. With the review of [R 1's] medications, it was determined that he could not be on Haldol." During an interview with the Consultant Pharmacist (CP) and the National Consultant Director (NCD) of the facility's pharmacy on 7/15/26 at 2:46 PM, when informed about R 1 being administered Haldol from 3/13/26 until 6/9/26 when R 1's Haldol had been discontinued on 1/28/26, the CP stated, "We recognize the unnecessary medication. Clearly that medication was not intended for that resident and by definition it meets the unnecessary medication." During interview of the DON on 7/15/26 at 4:58 PM, the surveyor asked the DON if R 1 was supposed to be administered with Haldol from 3/13/26 until 6/9/26. The DON stated, "If not ordered for him, he's not supposed to get that medication. He got the medication unnecessarily."			F0605			08/01/2026
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, facility policy and medical record reviews, the facility failed to ensure Haloperidol (antipsychotic medication) was not administered after it was discontinued for one (R 1) of one resident reviewed for significant medication errors. Findings include:			F0760	"Past Noncompliance - no plan of correction required"		06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0760 SS = E	Continued from page 5 Review of the facility's Medication and Treatment Orders policy dated 2/2024, revealed under Policy Statement, "Orders for medications and treatments will be consistent with principles of safe and effective order writing." Further review of the same policy revealed under Policy Interpretation and Implementation, "1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state...7. Orders for medications and treatment will be transcribed accurately..." Review of R 1's electronic health record (EHR) revealed diagnoses which included generalized anxiety disorder. Furthermore, R 1 was admitted to hospice on 11/20/25. Review of R 1's physician's orders from December 2025 until June 2026 revealed that R 1 had orders for, "Haloperidol Lactate Oral Concentrate 2 mg [milligrams]/ml [milliliter]...Give 0.25 ml [0.5 mg] by mouth three times a day for agitation" and "Haloperidol Lactate Oral Concentrate 2 mg/ml...Give 0.25 ml by mouth every 2 hours as needed for agitation" both with the original start date of 12/23/25. Further review of R 1's physician's orders from December 2025 until June 2026 revealed an order dated 1/28/26 which indicated, "...Discontinue all Haldol [Haloperidol] orders..." Review of Medication Error Reconciliation Form for R 1 revealed the Licensed Practical Nurse (LPN) 1 as the name of person who made the error. Further review of the same form revealed, "...Description of Error...Haloperidol was added to resident chart...Nursing Error...Transcription Error..." The form also indicated, "...Investigation Summary Completed by DON [Director of Nursing] or Designee: Reviewed order entry by [name of LPN 1] and was put in 03/13 [2026]. Nurse reported "I thought I dc'd [discontinued] the wrong order and put it back in." Noted similar order in PCC [electronic health records] during this time period for another resident...Haldol entered into this resident's chart in error..."			F0760			06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0760 SS = E	Continued from page 6 Review of R 1’s Medication Administration Record (MAR) for the months of March 2026 until June 2026 revealed that R 1 had received Haloperidol Lactate Oral Concentrate 2 MG/ML 1.5 ml (3 mg) by mouth at bedtime for terminal agitation from 3/13/26 until 6/9/26. Further review of R 1’s EHR revealed that there were no telephone or verbal physician orders and related documentation in R 1’s Progress Notes that indicated the resumption of Haloperidol for R 1. In an interview with LPN 1 on 7/14/26 at 2:26 PM, when asked about R 1’s Haloperidol order and significant medication error which involved R 1, LPN 1 stated, “It was three months ago, I thought I took the order out. [R 1] still has medications in the medication cart, so I put the order back in. I thought I accidentally discontinued it, so I put it back in.” LPN 1 further stated, “They said I might have mistaken it for another resident’s medication order. The hospice doctor discontinued [R 1’s] Haldol.” In a concurrent interview with the Regional Nurse Consultant (RNC) and the DON on 7/15/26 at 10:33 AM, when asked how the medication error was identified, the DON stated, “The Pharmacist Consultant was recommending a GDR [gradual dose reduction] for Haldol.” The RNC added, “[Name of the Nurse Practitioner] was going to address the GDR documentation then deferred it to hospice. Hospice then said [R 1] is not taking that.” The RNC further stated, “[Name of the DON] updated the facility’s/hospice’s medical director of the incident and the medical director called back [name of the DON] and stated that she did not have an order for it. [Name of the hospice company] discontinued Haldol.” The RNC also stated, “We needed to make sure we have a good process in place for order entry and monitoring and to make sure there are no errors and process to address if there are errors.” In an interview with the DON on 7/15/26 at 4:58 PM, the DON acknowledged a significant medication error had occurred involving R 1. The DON narrated, “I’m definitely disappointed. Nurses should be doing triple checks when entering orders. If she used our checklist, this would never have happened. The checklist should guide nurses on how to appropriately process orders and have everything completed.” The DON also shared, “I was not aware that PCC [electronic medical record] was integrated with [name of the facility’s pharmacy]. There was no signed document that was faxed to the pharmacy,			F0760			06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245517		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 OAKLAWN AVENUE , MANKATO, Minnesota, 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
F0760 SS = E	Continued from page 7 but the medication was filled.” When asked how the significant medication error went on for about three months and what were her expectations of nursing staff to prevent this from happening again, the DON stated, “Hospice plan of care is faxed after every hospice nurse visit which they update with new orders. I expect the nursing staff to go to that specific area which says orders and treatments and if they have a question, they should reach out to the provider, in this case hospice, and get the order clarified before finishing the order. [LPN 1] was under the impression that she discontinued it out of [R 1's] chart. She should have run the checks to find out if she had discontinued the order. She would have found out that the last time it was discontinued was in January.” This was a past noncompliance after the facility implemented interventions which were completed on 6/17/26. The corrective actions included the following: The facility created an order entry process for nurses to follow immediately. The facility also revised the Order Checklist to be completed with every order. All staff nurses, including agency nurses, were educated on the actions taken. A facility-wide audit of all residents’ medications was conducted to make sure all medication orders were transcribed accurately and verified with the medical providers. The DON and RNC have been doing random audits of physician orders twice a week The corrective actions were verified prior to exit from this survey. Interviews of staff nurses, LPN Care Coordinators and Nurse Managers revealed that they were all able to articulate the new order entry process. Random inspection of medications in the medication carts revealed that resident medications had corresponding physician orders.			F0760			06/18/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 15, 2026

Administrator
OAKLAWN HEALTH CARE, LLC
201 OAKLAWN AVENUE
MANKATO, MN 56001

RE: CCN: 245517

Cycle Start Date: June 10, 2026

Dear Administrator:

On July 28, 2026, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

The Minnesota Department of Health completed a revisit on August 14, 2026, and a Federal Monitoring revisit on August 14, 2026. Additionally, the Minnesota Department of Public Safety completed a revisit on August 17, 2026, to confirm that your facility had attained and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 10, 2026, did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 10, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 10, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 14, 2026, 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.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 15, 2026

Administrator
OAKLAWN HEALTH CARE, LLC
201 OAKLAWN AVENUE
MANKATO, MN 56001

Re: Reinspection Results
Event ID: 236237-H2

Dear Administrator:

On August 14, 2026 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 June 18, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.