Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2024

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

RE: CCN: 245517
Cycle Start Date: October 27, 2023

Dear Administrator:

On November 13, 2023, we notified you a remedy was imposed. On December 19, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 18, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 27, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 13, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 27, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 3, 2024

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

Re: Reinspection Results
Event ID: G5MZ12

Dear Administrator:

On December 19, 2023, 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 October 27, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
November 13, 2023

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

RE: CCN: 245517
Cycle Start Date: October 27, 2023

Dear Administrator:

On October 27, 2023, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 27, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 27, 2024, (42 CFR 488.417 (b)).

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 28, 2023, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 28, 2023, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 27, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Oaklawn Care & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 27, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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, Licensing and Certification Program 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 April 27, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 DENIAL OF PAYMENT

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:

Steven.Delich@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 Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 13, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: G5MZ11

Dear Administrator:

The above facility was surveyed on October 24, 2023 through October 27, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	C 10/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/24/23 thru 10/27/23, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. The IJ began on 10/9/23 at 9:05 p.m., when facility staff did not use two staff to transfer R1 in accordance with the care plan and follow manufacturer guidelines for Med Care lift that had expired. The regional director of operations (RDO), Administrator, the Interim director of nursing (DON) and regional nurse consultant (RNC) were notified of the IJ on 10/26/23 at 4:19 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 10/27/23. The following complaints were reviewed: H55176417C (MN00097646, MN00097621 and MN00097699) with deficiencies cited at F689-IJ, and F609 with incidental findings at F690. The following complaints were reviewed: H55176416C (MN00097532, MN00097580 and MN00097706) with no deficiency cited. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	C 10/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 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.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	C 10/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure timely reporting to the State Agency (SA) was completed when 1 of 1 resident (R1) fell from a mechanical lift as a result of NA not following the care plan which resulted in a right femur fracture. Findings include: Facility reported incident (FRI) submitted to the SA on 10/10/23, at 4:35 p.m. identified R1 had a fall from the mechanical lift on 10/9/23, at 9:05 p.m. that resulted in R1 fracturing his right femur, when NA-C transferred R1 via sit to stand to toilet. R1 became weak and fell from lift. NA-C notified nurse immediately. Nurse came immediately assessed that R1 was in pain, called 911 for transfer to emergency room (ER). Provider and family made aware. R1's quarterly Minimum Data Set (MDS) dated 6/8/23 indicated R1 had diagnoses of monoplegia (weakness) of the right side, unspecified dementia, cerebral infarction (stroke), anxiety, and depression. The cognition section was not completed for this assessment, however, MDS dated 3/14/23, indicated R1 did not have cognitive impairment. R1's progress notes dated 10/9/23, included R1 was being assisted by staff and had a fall. R1 was lying on the floor on his back crying, stating "I think I broke my leg it hurts so bad" Call placed to the nurse manager and agreed resident to send R1 to ER. Ambulance arrived at 9:40 p.m., R1 was transferred to the hospital at 9:56 p.m. Notes indicated a call was placed to the ER,	F 609	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: Facility reported incident on 10/10/23 at 4:35pm How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficiency. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Administration filed an OHFC report with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245517	A. BUILDING _____ B. WING _____	C 10/27/2023

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

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F 609	Continued From page 3 facility was notified R1 sustained a right femur fracture and admitted to the hospital During an interview on 10/25/23 at 1:04 p.m. DON stated she was made aware of the incident on 10/10/23, when she arrived at work around 8:00 a.m. DON explained the required time frame for reporting incidents was 2 hours for abuse or serious injury. During an interview on 10/25/23 at 10:05 a.m., Administrator stated he was aware they did not report the incident timely as they were more focused on ensuring the safety of their residents. Additionally, we were doing education with staff on the use of mechanical lifts used by the facility and their investigation. Administrator was aware of the reporting requirement. Review of the facilities policy Abuse Prohibition/Vulnerable Adult Policy dated 9/2023 indicated avoidable falls with serious injury shall be reported to the SA through the online reporting process immediately but not later than 2 hours after identifying the injury.	F 609	state agency on 10/10/23 RDO-A educated administrator regarding abuse reporting and investigations. Administrator educated DON, Social Service Director, and Corporate Nurse leader on abuse reporting and abuse reporting timeliness Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: Admin or designee will complete audits on grievances and risk management - incident reports 3x per week for 2 weeks, or as incidents/grievances allow. Administrator will bring and discuss audits to QAPI meeting every 2 months to review audits and to identify any additional reportable incidents. All future Risk management/incident reports will be reviewed for potential abuse/neglect/maltreatment and signed off by Admin, Social Services and DON.	
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		12/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 4 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure safe mechanical lift transfers were completed along with following manufacturer guidelines for Med Care lift that expired, and ensuring correct sling/harness sizes for 7 of 7 residents (R4, R5, R6, R7, R8, R9, R10) who utilized this mechanical lifts. This resulted in an immediate jeopardy (IJ) for R1 who fell from the Med Care sit to stand lift resulting a fractured right femur (thigh bone) on 10/9/23. This had the likelihood for serious harm, impairment or death for R4, R5, R6, R7, R8, R9 and R10 who continued to use this Med Care sit to stand lift. In addition, the facility failed to ensure a preventive lift maintenance program was followed and staff had knowledge of using the correct size harness/sling size for their mechanical lifts. The IJ began on 10/9/23 at 9:05 p.m., when facility staff did not use two staff to transfer R1 in accordance with the care plan and follow manufacturer guidelines for Med Care lift that had expired. The regional director of operations (RDO), Administrator, the Interim director of nursing (DON) and regional nurse consultant (RNC) were notified of the IJ on 10/26/23 at 4:19 p.m. The IJ was removed on 10/27/23 at 12:30 p.m., but the deficiency remained at a lower scope and severity of a E with no actual harm with potential for more than minimal harm that	F 689	Plan of Correction—F689 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: àD.G. has been transferred to Mayo ED for further treatment. Upon his return he will be re evaluated for transfer status by therapy and his care plan will be adjusted accordingly. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficiency. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:	

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F 689	Continued From page 5 was not immediate jeopardy. Findings include: R1's facility reported incident (FRI) dated 10/10/23, indicated nursing assistant (NA)-A transferred R1 via sit to stand to toilet. R1 became weak and fell from the lift. NA-A notified registered nurse (RN)-A immediately. RN-A assessed the resident noted to be in pain and called 911 for transfer to the emergency department (ED). R1's face sheet indicated diagnoses of dementia, right sided weakness from stroke, disorientation, restlessness, agitation, and fractured lower right femur (10/9/23). R1's quarterly Minimal Data Set (MDS) dated 9/8/23 indicated R1 required extensive assist of two staff for bed mobility, transfers, toileting, and dressing. R1 did not walk and used a wheelchair. No history of falls and no range of motion (ROM) impairments. The cognition section was not identified on this assessment, or 6/8/23 assessment. For the significant change MDS assessment dated 3/14/23, indicated R1 had intact cognition and had no behaviors. R1's care plan for transfers dated 7/23/22, indicated assist of two staff with mechanical lift. No indication of which lift or sling/harness size. Review of facility's Care Sheet (sheet for NAs to direct resident care) dated 10/24/23, after the fall, indicated R1 required assist of 3 staff and mechanical lift. Care sheet did not mention which mechanical lift or size of sling/harness to use.	F 689	The facility has audited all resident transfer status and has ensured that the therapy order, matches the care plan, and matches the care sheet. Therapy will communicate residents transfer status (for new residents or changes in current residents) with nurse manager, floor nurse, and DON through therapy update forms. This therapy form includes change in residents transfer status. Nurse manager or floor nurse will then select proper sling for the resident (if applicable) and note the size of the sling on care sheets – slings will be selected based on manufacturer recommendations and size of resident to ensure safety. Floor nurses will be provided materials and educated on assessing residents to find proper sling size for 24hr coverage. If changes occur floor nurses will be able to add to the care plans by writing on them, signing them and distributing the updated copy. Nurse managers will update the care plans in our computer system at their next available time The facility conducted a root cause analysis, and determined that the C.N.A. responsible for the transfer was aware of the care sheets, and how to use them, but failed to follow the plan of care. This C.N.A. was suspended immediately after D.G. care needs were met. The facility has re-educated all nursing staff on the importance of utilizing the care sheets, prior to the start of their next shift. (The facility has communicated this	

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F 689	Continued From page 6 R1's progress note dated 10/9/23, identified the following: Review of R1's progress notes indicated on 10/9/23: -11:10 p.m. call placed to Mayo ER (emergency room) department and spoke with the ER nurse and stated resident did have a fractured right femur and was admitted to the hospital. -11:38 p.m. resident was being helped with bedtime cares by staff when this writer was called to resident's room. Upon arrival, resident was lying down on the floor on his back crying and stating I think I broke my leg it hurts so bad. Assessment done, resident was unable to move his right leg and with passive range of motion. Resident kept screaming stating it hurts. Right leg was warm to touch and slightly bent sideways. Nurse manager and agreed resident to send R1 to ER, family member informed of the incident. Emergency Medical Services arrived at the facility at 9:40 p.m. and left accompanied with paramedics at 9:56 p.m. to the ER. -10/10/23 at 1:40 a.m., above incident happened on 10/9/23 at 9:05 p.m. Facility incident report dated 10/9/23, did not identify a causal factor to the fall for R1. R1's hospital discharge summary dated 10/18/23, indicated on 10/9/23 R1 had a fall from a hoyer lift and per x-ray was found to have a broken distal (bottom end) right femur (thigh bone) that also involved his right knee replacement. R1 had surgery to fix the fracture and returned to the facility on 10/18/23 with non-weight bearing (NWB) status to the right leg. During an observation of transfers with R1 on 10/24/23 at 4:29 p.m., R1 was assisted by three	F 689	education through phone calls and text messages for all staff already.) The facility is conducting random lift audits to insure staff competence in transfers. The facility is conducting random staff knowledge audits to insure that the education has lead to an operational change. Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: Therapy Director or designee will complete an audit 2x a week for 3 weeks to determine if all active therapy orders are expressed through resident caresheets/care plans for resident requiring stands or lift transfers Administrator will audit all lift and stand preventative Maintenace checklists 1x a month for 3 months starting on 11/27 ensure that all stands and lifts have been reviewed by Maintenace director. Maintance director will also report preventative Maintenace schedule during facilities QAPI. DON or designee will audit lift and stand competencies for staff who work on the floor for 3 weeks	

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F 689	Continued From page 7 staff members to transfer from his wheelchair to a recliner in the commons area via EZ full body lift. The lift sling was already under him and the 3 staff members, one to support R1's right leg, one to pull R1 back into the recliner and one to run the lift. Sling loops were attached to the lift and double hooked. During the transfer the sling was incorrectly placed too high as a result R1's upper buttocks was hanging through the sling and his pants were sliding down. The sling should be two inches below R1's tail bone and the top of the sling parallel to the base of the neck per manufactures recommendations. NAs did not stop the transfer or lower resident to reposition the sling. R1 stated, "everyone can see my butt". Staff lowered R1 into the recliner, removed the loops from the EZ full body lift and raised the foot of the recliner and left the sling under R1. Review of the EZ Way Sling Sizing Chart (undated) identified the sling should be two inches below R1's tail bone and the top of the sling parallel to the base of the neck. During an interview on 10/25/23 at 10:23 a.m., NA-T stated he worked the day of R1's fall on 10/9/23 at 9:05 p.m. NA-T heard R1 scream and went to R1's room and saw R1 on the floor next the head of the bed with the Med Care sit to stand in front of him. NA-A was holding the harness. NA-T stated he had gone over the care sheets with NA-A making sure to let NA-A know that R1 was assist of two staff for all transfers, at the beginning of the shift and gave NA-A a radio to call and ask questions. He could not remember what size sling R1 was using at time of the fall. NA-T also stated the nurse manager assessed the resident to determine the correct harness size. If this was not on are the care sheet,he	F 689	Completion date: 12/18/2023	

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F 689	Continued From page 8 would ask the nurse or nurse manager. During interview on 10/25/23 at 11:24 a.m., RN-A stated she was working the shift of R1's fall. RN-A was at the nurses' station when NA-A came out of R1's room and asked for help. RN-A stated NA-A was transferring R1 from wheelchair to commode with the Med Care sit to stand lift by herself when R1 slid down to the floor. RN-A stated the care plan stated transfer with assist of 2 staff with sit to stand lift. RN-A could not articulate who decided what size sling/harness to use or what size harness R1 used at the time of the fall. During observation on 10/24/23 at 4:03 p.m., the facility identified they were using the following mechanical lifts for their current resident: -Med Care - Care Stand Total support Model number 400002, six lifts all with a large size harness hanging across the lift. Seven residents used these lift (the facility refers to this lift as EZ stand in their documentation). -EZ Lift total body lift, 3 lifts, slings located on residents or in their rooms, 14 residents used this lift. R4 R4's face sheet indicated the following diagnoses, dementia with behavioral disturbances, osteoporosis and history of falling. R4's quarterly MDS dated 9/18/23, indicated R4 had impaired cognition and required extensive assist of one for transfers, bed mobility and toileting. R4's had one fall without injury prior to assessment and used a wheelchair. R4's care plan therapy recommendations R4 was assist of 1 staff with EZ stand (Med Care Stand)	F 689		

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F 689	Continued From page 9 for all transfers including toileting, dated 6/25/18. Care plan lacked identification of what size harness to use. Review of the R4's facility's care sheets 10/24/23 indicated transferred with EZ stand (Med Care Stand) and assist of one but did not identify the size of harness R4 required for safe transfer. R4's Lift and Mobility status form dated 6/20/23, indicated R4 was assist of one staff with EZ stand (Med Care lift). There was no harness size identified. R5 R5's face sheet indicated the following diagnoses of cervical disc disorder with myelopathy and severe sepsis with septic shock. R5's nursing assessment dated 10/18/23, indicated an intact cognition and transferred with physical assist of two staff, had ROM impairments to his lower extremities, used a wheelchair and no history of falls. R5's care plan dated 10/24/23, direct staff to transfer R5 with mechanical lift and max assist of two for bed mobility. Review of the facility's care sheets for R5 dated 10/24/23, indicated R5 transferred with mechanical lift and max assist of two for bed mobility. Care sheets did not indicate which mechanical lift or the size of sling/harness to use for R5. R5's record lacked a comprehensive assessment to determine which mechanical lift including sling/harness R5 required to ensure they were	F 689		

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F 689	Continued From page 10 safe during these transfers. R6 R6's face sheet indicated the following diagnoses vertebrogenic low back pain, systemic lupus erythematosus, osteoporosis, and wedge compression fracture of fifth vertebra. There was no MDS available for R6. R6's alteration in mobility care plan indicated R6 transferred with mechanical lift and assist of two staff, start date of 10/17/23; TLSO (ridged back brace) to be worn when out of bed and when head of bed greater than 30 degrees, no bending, twisting or lifting greater than 10 pounds, start date of 10/18/23. Care plan did not indicate which mechanical lift to use for R6. Review of the facility's care sheet 10/24/23 indicated R6 transferred with EZ stand (Med Care) and assist of two staff. Care sheets lacked the size of harness R6 used for safe transfer. R6's lift and mobility status assessment dated 10/24/23, indicated R6 transferred with assist of two staff and EZ stand (Med Care lift). The lift harness size was not identified. R7 R7's face sheet indicated the following diagnoses acute kidney failure and weakness. R7's care plan indicated an alteration in mobility related to acute kidney injury, chronic obstructive pulmonary disease, major depressive disorder and atrial fibrillation as evidenced by needing assistance with cares, dated 10/19/23. The following interventions were in place:	F 689		

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F 689	Continued From page 11 -assist of one staff for ambulation, start date 10/19/23, -assist of one staff with movement in and out of bed, start date 10/19/23, -maximal assist of two staff for transfers, use mechanical lift stand from low surfaces. Max assist of two staff for bed mobility, does not ambulate at this time. Transfers with assist of two staff and two wheeled walker in room. Can use EZ stand (Med Care) if patient is tired in evening, start date 10/19/23. There was no mention of the harness size. Review of the facility's care sheet indicated R7 transferred with assist of two and a two wheeled walker in and R7 could use the EZ stand (Med Care) if tired in the evening. There was no mention of harness size. R7's lift and mobility assessment dated 10/17/23, indicated R7 transferred with maximal assist of two and mechanical stand per therapy recommendations. Staff to continue to monitor for safety. There was no mention of which mechanical lift or harness size to use for R7. R8 R8's face sheet indicated the following diagnoses of spondylosis without myelopathy or radiculopathy, cervical region, weakness, osteoporosis, and spinal stenosis cervical and lumbar region. R8's quarterly MDS dated 9/12/23, indicated R8 required assist with transfers and did not walk. R8 used a wheelchair. Cognition section not filled out for this assessment, previous quarterly assessment dated 6/16/23, indicated intact cognition. R8 had no history of falls.	F 689		

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F 689	Continued From page 12 R8's alteration in mobility care plan indicated R8 transferred with EZ stand (Med Care), assist of two with movement in bed and in/out of bed, dated 8/13/21. There was no mention of harness size for R8. Review of the facility's care sheet dated 10/24/23, R8 was assist of one with EZ stand (Med Care). There was no mention of harness size to use for R8. R8's record lacked a comprehensive assessment to determine which size sling/harness R8 required to ensure they were safe during these transfers. R9 R9's face sheet indicated the following diagnoses of stroke, and cervicalgia. R9's annual MDS dated 9/7/23, indicated an intact cognition and required maximal assist with transfers and did not walk. R9's alteration in mobility care plan indicated R9 transferred with assist of 1 and EZ stand (Med Care), did not ambulate, and assist of one with movement in bed and in/out of bed, start date of 10/5/20. Review of the facility's care sheet dated 10/24/23, indicated R9 transferred with EZ stand (Med Care) with assist of one staff with medium harness. Even though the facility only had large harnesses on the floor in use as a result of the observation on 10/24/23 at 4:03 p.m.. R9's record lacked a comprehensive assessment	F 689		

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F 689	Continued From page 13 to determine which size sling/harness R9 required to ensure they were safe during these transfers. R10 R10's face sheet indicated the following diagnoses of weakness, and age-related disability. R10's quarterly MDS dated 8/18/23, indicated R10 was dependent on staff for transfers, no history of falls, did not walk and used a wheelchair. R10's fall risk care plan indicated R10 was assist of two staff and EZ stand (MedCare), start date 10/10/23. Transfer care plan indicated EZ stand (Med Care) and assist of one staff, dated 8/1/19. Review of the facility's care sheet dated 10/24/23, indicated R10 transferred with EZ stand and assist of two staff. Care sheet lacked what size of harness R10 needed to transfer. R10's record lacked a comprehensive assessment to determine which sling/harness size, R10 required to ensure they were safe during these transfers. During an interview on 10/25/23 at 9:31 a.m., NA-R stated staff follow the care plan/care sheets to transfer residents. NA-R looked at the care sheet and stated it did not state which harness size to use with the Med Care sit to stand lift. NA-R could not remember when she last had training on the lifts the facility used. NA-R stated the sit to stand lifts should say on the care sheet whether one or two staff needed and there are always two staff with the EZ lift.	F 689		

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F 689	Continued From page 14 During an interview on 10/25/23 at 9:39 a.m. NA-S and NA-A stated they would look at the care sheets for how to transfer any resident, if not there they would ask the nurse manager. During an interview on 10/25/23 at 12:55 p.m., speech therapist (ST)-A, director of therapy, indicated therapy does an initial assessment of new admissions for proper transfer techniques for resident. Therapy would tell nursing which type of mechanical lift to use but nursing would have to identify the sling/harness size to use as part of their nursing assessment. There is no formal assessment kept in our therapy notes for the lift they are to use, we just recommend the lift type to nursing staff. During an interview on 10/25/23 at 2:40 p.m., NA-T stated nurse managers indicated the size of harness used for the EZ stand (Med Care) and there was a chart on the EZ lift to determine what sling to use. During an interview on 10/25/23 at 2:56 p.m., licensed practical nurse (LPN-B) who was the nurse manager, stated sling/harness sizes should be in the therapy orders as therapy does the transfer assessment. If not, they would base it off resident weight in their chart and put on the care sheet. NAs could look at therapy notes as well. During an interview on 10/25/23 at 3:00 p.m., RN-C stated she would rely on the NA's as they are competent on knowing what size of sling/harness to use. RN-C would check therapy notes as therapy does an assessment when residents admitted. If residents are on the LTC side then the nurse assessment should show	F 689		

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F 689	Continued From page 15 which size to use. The facility's copy of the manufacture's operation manual, revised date 9/2010, page 9 - 11, informed reader how to operate the Med Care - Care Stand, but there was no sizing guide for harnesses even though the facility had other sizes. The facility also did not use a guide or any reference to determine harness size for each resident who used Med Care lift. Preventative Maintenance During an interview on 10/26/23 at 8:15 a.m. MM-A indicated preventative maintenance (PM) was completed monthly on all the lifts. Review of facility's form labeled, "Weekly audit for functionality for all facility lifts and stand wear/tear on slings". The form had four areas labels: stand/lift number, location, functioning properly yes/no and slings in good working condition yes/no. Under stand lift identified the stand number (Med Care) and lifts (EZ Lift). The location was identified as east, west or north wing. Functioning properly column identified a yes or no. The column slings in good working condition only identified the stands (Med Care) as yes, there were no notion if the EZ lift slings were reviewed. MM-A stated he would test the buttons of the lift so they would go up and down, tested the emergency stop button and made sure the lifts rolled well by rolling it around in a circle. MM-A was not able to articulate the manufactures recommendations for PM and did not use manufactures provided check list for PM. MM-A completed PM on 10/10/23 on all lifts per his	F 689		

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F 689	Continued From page 16 checklist and was unsure if the lift involved in R1's incident was removed from the floor until MM-A performed PM on it before returning it to the floor for use. He was unable to articulate the age of the lifts in use or other specific about the required maintenance by the manufacturer. Review of the Med Care's manufacture's operation manual model number 400002, revised 9/2010, on page 24-25 indicated the routine maintenance was a vital component to keeping the equipment in safe operating condition. A machine that is not properly maintained could create potentially hazardous situations for nursing staff and patients. Check list were to used for PM. The PM checklist had two column, pass or fail. Under general maintenance indicated the following: -Actuator and connections- check the operation of the actuator. Remove bolts and check for lithium grease. If none present, apply and re-insert. Use of a thread locker is recommended when re-attaching nut to bolt. -Actuator- check the up and down movement. If it makes noise or wobbles, it should be inspected. -Actuator cover- clean and check for wear and tear. -Base cover- clean and check for cracks and sharp edges. -Boom/arm pivot pins and bushings- check the area where the arm or boom meets the mast. Be sure the nut and bolt are securely attached. If not operating smoothly, remove bolt and apply lithium grease. Re-insert the bolt; apply thread locker, and secure nut. -Front casters- clean debris from casters and test for smooth rolling. -Hand control- check for smooth operation.	F 689		

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F 689	Continued From page 17 -Leg covers- clean and check for sharp edges- -Leg bolts- remove base cover and check to make sure bolts are flush with the base. If not, tighten. Periodically remove bolts, apply lithium grease, and re-insert using thread locker on the threads. -Leg spreader pivot bar- check the bolt on the base and make sure the nut is at least 2 threads inside the end. This nut may be adjusted to your preferred tension. -Mast/base bolts- check bolts to make sure they are re tight. If not, remove, apply thread lock and re-tighten. -Rear casters- clean and remove debris. Check to make sure the brakes are working properly and that the wheels are firmly attached. -Receiver box- clean and check for operation. Check that the on/off switch is functioning properly. Try out the toggle switch, and verify both the up and down motion of the actuator. -Batteries- check for damage to plug, and check voltage. -Slings/harness and belts- inspect slings/harness and belts for wear and tear before every use. Immediately remove any damaged slings/harness and belts from service and replace. Under the stand maintenance it indicated the following: -Foot platform- remove the platform and clean. Be sure to remove the plastic footplate cover and clean underneath. Pay attention to the plastic and check for sharp edges. -Knee pad assembly- check for tears and clean the leg strap and surface of pad. -Padded hand grips- clean hand grips, and check that they are pushed all the way on. -Arm pads- clean and check for wear and tear. -Foot pedal- check for smooth operation.	F 689		

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F 689	Continued From page 18 In addition, the manufacture recommended replacement of the following: -Actuators to be replaced after 4 years of use -Support bar on lifts replace when excessive wear is apparent -Slings to be replaced after 2 years of use. During an interview on 10/25/23 at 4:38 p.m., Med Care representative (CSR-A) stated the harness sizing was based on the resident's waist measurements. The Med Care lift, model number 400002 (the lift the facility used) were manufactured in 2009 was discontinued in 2015. All the facilities that had this lift received a Tech Bulletin identifying the manufacture would continue to supply parts for 7 years after the discontinuation date (2021). The unit should not be used longer than this date, they could not ensure the safety of the resident during transfers with these lifts. CSR-A identified Med Care's expectation is the facility would report any incident involving their equipment to them. During an interview on 10/25/23 at 1:04 p.m., DON could not state the Med Care sit to stand lift R1 fell from was removed from the floor until the next morning when MM-A inspected it. DON also stated that the facility did not have a mechanical lift policy but followed the manufactures recommendations. During a clarification interview on 10/26/23 at 8:35 a.m., DON confirmed that all Med Care harness were size large that were on the floor. Other sizes were stored in the basement and available if needed. DON was not able to identify how the harness or sling size was determined for each resident. She was also unaware the Med Care- Care Stand Total support, model number 400002 was retired in	F 689		

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F 689	Continued From page 19 2015 and no longer supported by the company. During an interview on 10/26/23 at 10:11 a.m., RDO and Administrator both acknowledged they did not know there was a life span to lifts or that the Med Care- Care Stand Total support lift the facility was using was discontinued in 2015. Further more, they were not aware the facility did not have a system in place for harness sizing for safe transferring of residents with the Med Care-Care Stand Total support, model number 400002. During an interview on 10/26/23 at 1:37 p.m., the food and drug administration (FDA), stated the Med Care Stand, model number 400002 was no longer registered with the FDA. If the facility continued to use the unregistered device, the facility needed to have someone that supported the product to render it safe to use. The FDA further stated that if the expired device was involved in an incident that may have resulted in serious harm or death, the device would need to be reported to the FDA by the manufacturer under 42 CFR 803.3, it did not matter if the incident was caused by operator error or equipment failure. During an interview on 10/25/23 at 3:31 p.m., with EZ Way Lift representative stated the sling sizes was based on the sizing charts that are on each lift. The slings are color coded per size based on weight. The chart also explains and shows how to place the slings properly for a safe transfer of the resident. The immediate jeopardy that was identified on 10/26/23 at 4:19 p.m., was removed on 10/27/23 at 12:30 p.m., when it was verified, the facility implemented the following corrective actions:	F 689		

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F 689	Continued From page 20 -Review manufacture's recommendations in conjunction with their mechanical lift transfer policy and procedures -Revise policy/procedure to ensure they are being used according to manufacture guideline -Remove all Med Care standing lifts that are not supported by manufacturer from the floor -Inspect all lifts for safe operation according to manufactures recommendations -Develop and educate nursing/physical therapy (PT)/ occupational therapy (OT) on completing comprehensive harness/sling assessments in accordance with manufacture's recommendations and develop/revise care plans as appropriate -Educate staff on appropriate positioning of the slings/harness and immediately removing equipment from service following an incident -Complete a return demonstration after education on all staff who use the mechanical lift, to ensure they are following facility policy and manufacture guidelines for a safe transfer.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		12/11/23

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F 690	Continued From page 21 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure proper catheter cleaning and storage was provided to prevent possible urinary tract infections (UTIs) for 4 of 6 residents (R1, R3, R5 and R15) observed for catheter use. Findings included: R1's quarterly Minimum Data Set (MDS) dated 6/8/23, identified R1 had diagnoses of neurogenic bladder (define what this is), cancer, urinary tract infections (UTI) in the last 30 days, diabetes, and stroke. R1 had an indwelling urinary catheter and was always continent of bowel. R1's bowel and bladder care plan 7/7/22	F 690	Plan of Correction—F690 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The facility changed the tubing and collection bag for identified residents.	

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F 690	Continued From page 22 indicated R1 had altered elimination related to impaired mobility and function due to hemiplegia and hemiparesis following right sided stroke, history of UTIs, sepsis, and bladder cancer scope done on 4/3/23 that showed friable tissue over posterior bladder wall. Additionally, R1 had history of TURBT (trans urethral resection of bladder tumor) on 5/16/23 with significant hematuria (blood in urine) and indwelling urinary catheter placement. Corresponding interventions included: -Followed by urology, start date 7/722. -assist of 2 with toileting, start date 7/7/22 -provide assist with peri cares a.m., HS (bedtime) and as needed, start date 7/7/22 -monitor for signs and symptoms of UTI, start date 11/29/22, -monitor foley output, start date 8/8/23 -Foley (brand of indwelling urinary catheter) catheter care to be done twice daily with no pressure from the catheter on the tip of his penis, start date 8/8/23 Review of the facilities care guide (abbreviated care plans used by nursing assistants) dated 10/24/23, directed for the catheter to be anchored to leg at all times to avoid pulling, toilet every 2-3 hours and as needed, catheter output every shift. R1's physician orders included: -Change Foley catheter every 30 days and as needed, 16 French (Fr) 10 milliliters (ml) at bedtime every 30 days make sure catheter is silicone, start date 9/22/23 -Foley catheter output three times daily, start date 9/22/23 R1's hospital discharge summaries indicted R1 had a history of UTI's with urosepsis (infection in	F 690	Facility updated the care plans of residents to include plan of care for catheters (if applicable) Facility assured that all catheter treatment orders were in place and in conjunction with care plans How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with catheters have the potential to be affected by the alleged deficiency. \ The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has educated staff on the facilities catheter policy including disinfecting, sterilizing, storing, and capping catheters as appropriate, Quality Assurance ,plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or designee will audit by observing nursing staff disinfecting and storing catheter drain bags properly 3 times per	

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F 690	Continued From page 23 the blood from UTI) with hospitalizations and emergency room (ER) visits from 12/30/22 through 10/24/23: -R1's hospital discharge summary dated 1/5/23, indicated R1 was admitted to the hospital on 12/30/23 with diagnoses of sepsis urinary tract infection (UTI). Lab results showed infectious bacteria found in R1's blood and urine were Staphylococcus Aureus. The summary indicated R1 was discharged from the hospital on 1/5/23, with intravenous antibiotic (IV). -R1's emergency room (ER) after visit summary dated 2/6/23, identified R1 was seen for UTI, and returned to the facility on oral antibiotics. -R1's hospital discharge summary dated 5/5/23, indicated R1 was admitted on 5/2/23 for UTI, sepsis, and confusion. R1's lab results showed infections bacteria of proteus mirabilis in urine. R1 was discharged back to the facility on 5/5/23, with oral antibiotics. -R1' hospital discharge summary dated 7/12/23, indicated R1 was admitted on 7/9/23, for altered mental status. R1's lab results showed infectious bacteria of staphylococcus Aureus from urethra wound and Escherichia coli (E. coli) and proteus mirabilis in his urine. R1 was discharged back to the facility on 7/12/23, with a Foley catheter and a midline intravenous access for IV antibiotics. -R1's hospital discharge summary dated 8/25/23, indicated R1 was admitted to the hospital on 8/23/23 for sepsis. R1's labs showed infectious bacteria E. coli in his urine. R1 was discharged back to the facility on 8/25/23, with oral antibiotics. During an observation on 10/24/23 at 5:16 p.m., in R1's bathroom, there was an overnight urine collection bag sitting in a pink basin on a shelf above the toilet. The tubing connector was not	F 690	week for 2 weeks. Floor nurses will ensure drain bags and catheters are stored and disinfected properly every shift for applicable residents. Catheter care checks will be added to nursing TAR for floor nurses to observe and verify per shift that floor staff properly store and disinfect catheter and catheter supplies. This will ensure that catheter cares are done properly moving foward past DON audit. Facility will review root causes of UTIs during every other month QAPI. Completion date: 12/11/2023	

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F 690	Continued From page 24 capped. The bag was not dated. Above the toilet was a sign taped to the wall for Indwelling Catheter Care Procedure and Disinfection of Urinary Drainage, instructions on how to change out the legs bag and the overnight urine collection bag, as well as the cleaning instructions. At 5:20 p.m. director of nursing entered R1's bathroom, DON looked into the basin and stated the connecting tubing was not capped. DON also verified placement of sign on the wall to direct staff to disinfect drainage bags. DON then took an alcohol swab and wiped the end of the tubing and applied the blue cap, did not throw the bag away or disinfect the bag. During an observation on 10/26/23 at 8:35 a.m., had DON, RN-B and NA-M verified the bed bag was not capped or washed was sitting in the pink basin in R1's bathroom. There was also a small amount of yellow fluid present in the bag and in the bottom of the bin. NA-M stated she had not had time to return to clean the bag. When asked what the importance of capping the bed bag before placing in the clean pink bin, DON responded, to prevent contamination of the catheter bag and introducing bacteria to the resident. It was the DON's expectation the urinary collection bags were cleaned prior to being placed into the pink basin as this was a clean basin. During an interview on 10/24/23 at 4:29 p.m., FM-A stated that R1 was prone to UTI's and had been hospitalized 3-4 times this year with sepsis and UTI's. FM-A stayed to visualized cares being done on R1 in the evenings and felt staff were not following their own policies for catheter care. FM-A sent pictures from her phone of the pink basin sitting on the floor in R1's bathroom with the	F 690		

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F 690	Continued From page 25 overnight bag uncapped in the basin or the connection tubing end on the floor uncapped. R3's annual MDS dated 9/21/23, identified R3 had diagnoses of multiple sclerosis (MS) and neurogenic bladder. R3 did not have cognitive impairment. Additionally, the MDS, identified R3 did not have a catheter and was frequently incontinent of bladder and always continent of bowel. R3's physician orders included the following: -Foley output every shift for catheter, start date 10/2/23 -Place foley catheter 16 Fr with 10 milliliters (ml's) balloon. Change on 2nd of every month and as needed (PRN) for overflow incontinence, start date 10/2/23. R3's bowel and bladder care plan dated 4/17/2018, indicated R3 had altered elimination related to diagnoses of MS, weakness, and flaccid neurogenic bladder. Corresponding interventions included: -Straight cath as needed for inability to void or empty bladder fully, start date 3/5/2020. -Total assist of 2 via full body mechanical lift for toileting every 2-3 hours and as needed, start date 4/17/18. -Monitor and report for signs and symptoms for UTI, start date 4/17/2018. In review of R3's care plan, it was not evident the care plan was revised to include goals and interventions for the care of the indwelling urinary catheter. Additionally, R3's nursing assistant care guide did not identify R3 required an indwelling catheter.	F 690		

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F 690	Continued From page 26 During an observation and interview on 10/26/23 at 8:46 a.m., R3 was sitting in electric wheelchair with a bed bag hooked on the bottom of the wheelchair. The bag was dated 10/12/23. There was a milky white liquid substance in the tubing and a white flaky substance on the walls of the tubing. The catheter was not secured to either of R3's legs. R3 stated that at times that "bed bag [overnight collection]" got caught on her wheels and the bag popped. This pulls on the tubing but has not pulled out the foley catheter. RN-B confirmed that the catheter bag should be changed weekly on bath days and that there was sediment built up in the tubing. R5 R5's 5-day MDS dated 10/19/23, indicated intact cognition with diagnoses of sepsis with septic shock, UTI in the past 30 days, benign prostatic hyperplasia (BPH)and urinary retention. R5 had an indwelling catheter and was always incontinent of bowel. R5's physician orders included the following: -change foley catheter (16fr with 10 ml's balloon) monthly and as needed. One time a day starting on the 1st and ending on the 1st each month for foley catheter cares, start date 10/24/23, -change foley/suprapubic catheter bag on hsower day in the morning every Tuesday, start date 10/20/23, -change graduate used for catheter output weekly, in the morning every Tuesday. R5's 10/24/23 care plan indicated alteration in elimination related to BPH with lower UTI symptoms. The following intervention were in place: -monitor foley catheter output, start date	F 690		

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F 690	Continued From page 27 10/24/23, -change foley catheter per policy, start date 10/24/23, -foley catheter care per policy. During an observation on 10/26/23 at 8:13 a.m. R5 sat in his recliner, his catheter bag dated 10/18/23, was lying on the floor next to the chair. R15 R15's 5-day MDS dated 9/8/23, indicated an intact cognition and diagnoses of cerebral palsy and BPH. R15 had an indwelling catheter and was always continent of bowel. R15's physician orders included the following: -change foley/suprapubic catheter bag on shower day, in the morning every Monday, start date 9/2/23, -change graduate used for catheter output weekly, one time a day every Monday, start date 9/2/23, -monitor catheter ourput every shift, start date 9/2/23. R15's 9/8/23 care plan indicated no alteration in elimination as R15 is continent of bowel. There following interventions were in place: -monitor foley catheter output, start date 9/8/23, -change foley catheter per policy, start date 9/8/23, -foley catheter care per policy. During an observation on 10/26/23 at 8:24 a.m., R15 had a catheter bag dated 10/16/23. Foley was secured to his left leg with an undated device. During an interview on 10/26/23 at 8:56 a.m.,	F 690		

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F 690	Continued From page 28 registered nurse (RN)-B stated catheter cares was the responsibility of the NA taking care of the resident. There was no place found on the MAR/TAR for nursing to sign off on catheter cares, just the changing out of the catheter itself on a monthly basis. During an interview on 10/27/23 at 9:31 a.m., nurse manager (NM)-A stated the nursing assistants (NAs) trade out the overnight bags to the leg bags when the resident was out of bed, NAs would then wash out the bags with vinegar, hang to dry, and then place them into a pink basin. The process of changing out the bags was completed per resident's preference and the bags were changed out weekly on the resident's bath day. NM-A reviewed the facility policy and indicated step 5 to uncap bottom outlet of bag, drain urine into measuring container, then recap outlet. NM-A stated wiping the outlet with an alcohol wipe prior to re inserting or closing the outlet should be part of the process. NM-A stated this voided step could lead to the introduction of bacteria/infection to the resident. During an interview on 10/25/23 at 5:17 p.m., DON stated it was her expectation staff complete catheter cares as the policy procedure stated. Recently has done one on one training with all staff. Review of the facilities policy Disinfection of Urinary Drainage Bag indicated should be completed daily when the urinary drainage bag was removed from the resident to leg bag and vice versa with the following steps: 5. uncap bottom outlet of bag, drain urine into measuring container, then recap the outlet. (Should be wiped with alcohol prior to recapping	F 690		

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	245517	A. BUILDING _____ B. WING _____	C 10/27/2023

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F 690	Continued From page 29 per NM-A interview on 10/27/23.) 16. Remove top cap. Partially fill the bag with 55-65 millimeters (ml's) of vinegar. 17. Shake the bag gently so the entire inside is rinsed well. 18. Drain vinegar from bag, store bag on clean towel or in clear plastic bag until next use; allowing exterior to air dry. 20. Change out bag for a new appliance on bath day.	F 690		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/24/23 thru 10/27/23, 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. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H55176416C (MN00097532, MN00097580 and MN00097706). The following complaints were reviewed. H55176417C (MN00097646, MN00097621 and MN00097699) with a licensing order issued at 0910. 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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure safe mechanical lift transfers were completed along with following manufacturer guidelines for Med Care lift that expired, and ensuring correct sling/harness sizes for 7 of 7 residents (R4, R5, R6, R7, R8, R9, R10) who utilized this mechanical lifts. This resulted in an immediate jeopardy (IJ) for R1 who fell from the Med Care	2 830	Corrected	12/11/23

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2 830	Continued From page 3 sit to stand lift resulting a fractured right femur (thigh bone) on 10/9/23. This had the likelihood for serious harm, impairment or death for R4, R5, R6, R7, R8, R9 and R10 who continued to use this Med Care sit to stand lift. In addition, the facility failed to ensure a preventive lift maintenance program was followed and staff had knowledge of using the correct size harness/sling size for their mechanical lifts. Findings include: R1's facility reported incident (FRI) dated 10/10/23, indicated nursing assistant (NA)-A transferred R1 via sit to stand to toilet. R1 became weak and fell from the lift. NA-A notified registered nurse (RN)-A immediately. RN-A assessed the resident noted to be in pain and called 911 for transfer to the emergency department (ED). R1's face sheet indicated diagnoses of dementia, right sided weakness from stroke, disorientation, restlessness, agitation, and fractured lower right femur (10/9/23). R1's quarterly Minimal Data Set (MDS) dated 9/8/23 indicated R1 required extensive assist of two staff for bed mobility, transfers, toileting, and dressing. R1 did not walk and used a wheelchair. No history of falls and no range of motion (ROM) impairments. The cognition section was not identified on this assessment, or 6/8/23 assessment. For the significant change MDS assessment dated 3/14/23, indicated R1 had intact cognition and had no behaviors. R1's care plan for transfers dated 7/23/22, indicated assist of two staff with mechanical lift.	2 830		

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2 830	Continued From page 4 No indication of which lift or sling/harness size. Review of facility's Care Sheet (sheet for NAs to direct resident care) dated 10/24/23, after the fall, indicated R1 required assist of 3 staff and mechanical lift. Care sheet did not mention which mechanical lift or size of sling/harness to use. R1's progress note dated 10/9/23, identified the following: Review of R1's progress notes indicated on 10/9/23: -11:10 p.m. call placed to Mayo ER (emergency room) department and spoke with the ER nurse and stated resident did have a fractured right femur and was admitted to the hospital. -11:38 p.m. resident was being helped with bedtime cares by staff when this writer was called to resident's room. Upon arrival, resident was lying down on the floor on his back crying and stating I think I broke my leg it hurts so bad. Assessment done, resident was unable to move his right leg and with passive range of motion. Resident kept screaming stating it hurts. Right leg was warm to touch and slightly bent sideways. Nurse manager and agreed resident to send R1 to ER, family member informed of the incident. Emergency Medical Services arrived at the facility at 9:40 p.m. and left accompanied with paramedics at 9:56 p.m. to the ER. -10/10/23 at 1:40 a.m., above incident happened on 10/9/23 at 9:05 p.m. Facility incident report dated 10/9/23, did not identify a causal factor to the fall for R1. R1's hospital discharge summary dated 10/18/23, indicated on 10/9/23 R1 had a fall from a hoyer lift and per x-ray was found to have a broken distal (bottom end) right femur (thigh bone) that also	2 830		

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2 830	Continued From page 5 involved his right knee replacement. R1 had surgery to fix the fracture and returned to the facility on 10/18/23 with non-weight bearing (NWB) status to the right leg. During an observation of transfers with R1 on 10/24/23 at 4:29 p.m., R1 was assisted by three staff members to transfer from his wheelchair to a recliner in the commons area via EZ full body lift. The lift sling was already under him and the 3 staff members, one to support R1's right leg, one to pull R1 back into the recliner and one to run the lift. Sling loops were attached to the lift and double hooked. During the transfer the sling was incorrectly placed too high as a result R1's upper buttocks was hanging through the sling and his pants were sliding down. The sling should be two inches below R1's tail bone and the top of the sling parallel to the base of the neck per manufactures recommendations. NAs did not stop the transfer or lower resident to reposition the sling. R1 stated, "everyone can see my butt". Staff lowered R1 into the recliner, removed the loops from the EZ full body lift and raised the foot of the recliner and left the sling under R1. Review of the EZ Way Sling Sizing Chart (undated) identified the sling should be two inches below R1's tail bone and the top of the sling parallel to the base of the neck. During an interview on 10/25/23 at 10:23 a.m., NA-T stated he worked the day of R1's fall on 10/9/23 at 9:05 p.m. NA-T heard R1 scream and went to R1's room and saw R1 on the floor next the head of the bed with the Med Care sit to stand in front of him. NA-A was holding the harness. NA-T stated he had gone over the care sheets with NA-A making sure to let NA-A know that R1 was assist of two staff for all transfers, at	2 830		

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2 830	Continued From page 6 the beginning of the shift and gave NA-A a radio to call and ask questions. He could not remember what size sling R1 was using at time of the fall. NA-T also stated the nurse manager assessed the resident to determine the correct harness size. If this was not on are the care sheet,he would ask the nurse or nurse manager. During interview on 10/25/23 at 11:24 a.m., RN-A stated she was working the shift of R1's fall. RN-A was at the nurses' station when NA-A came out of R1's room and asked for help. RN-A stated NA-A was transferring R1 from wheelchair to commode with the Med Care sit to stand lift by herself when R1 slid down to the floor. RN-A stated the care plan stated transfer with assist of 2 staff with sit to stand lift. RN-A could not articulate who decided what size sling/harness to use or what size harness R1 used at the time of the fall. During observation on 10/24/23 at 4:03 p.m., the facility identified they were using the following mechanical lifts for their current resident: -Med Care - Care Stand Total support Model number 400002, six lifts all with a large size harness hanging across the lift. Seven residents used these lift (the facility refers to this lift as EZ stand in their documentation). -EZ Lift total body lift, 3 lifts, slings located on residents or in their rooms, 14 residents used this lift. R4 R4's face sheet indicated the following diagnoses, dementia with behavioral disturbances, osteoporosis and history of falling. R4's quarterly MDS dated 9/18/23, indicated R4 had impaired cognition and required extensive assist of one for transfers, bed mobility and	2 830		

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2 830	Continued From page 7 toileting. R4's had one fall without injury prior to assessment and used a wheelchair. R4's care plan therapy recommendations R4 was assist of 1 staff with EZ stand (Med Care Stand) for all transfers including toileting, dated 6/25/18. Care plan lacked identification of what size harness to use. Review of the R4's facility's care sheets 10/24/23 indicated transferred with EZ stand (Med Care Stand) and assist of one but did not identify the size of harness R4 required for safe transfer. R4's Lift and Mobility status form dated 6/20/23, indicated R4 was assist of one staff with EZ stand (Med Care lift). There was no harness size identified. R5 R5's face sheet indicated the following diagnoses of cervical disc disorder with myelopathy and severe sepsis with septic shock. R5's nursing assessment dated 10/18/23, indicated an intact cognition and transferred with physical assist of two staff, had ROM impairments to his lower extremities, used a wheelchair and no history of falls. R5's care plan dated 10/24/23, direct staff to transfer R5 with mechanical lift and max assist of two for bed mobility. Review of the facility's care sheets for R5 dated 10/24/23, indicated R5 transferred with mechanical lift and max assist of two for bed mobility. Care sheets did not indicate which mechanical lift or the size of sling/harness to use for R5.	2 830		

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2 830	Continued From page 8 R5's record lacked a comprehensive assessment to determine which mechanical lift including sling/harness R5 required to ensure they were safe during these transfers. R6 R6's face sheet indicated the following diagnoses vertebrogenic low back pain, systemic lupus erythematosus, osteoporosis, and wedge compression fracture of fifth vertebra. There was no MDS available for R6. R6's alteration in mobility care plan indicated R6 transferred with mechanical lift and assist of two staff, start date of 10/17/23; TLSO (ridged back brace) to be worn when out of bed and when head of bed greater than 30 degrees, no bending, twisting or lifting greater than 10 pounds, start date of 10/18/23. Care plan did not indicate which mechanical lift to use for R6. Review of the facility's care sheet 10/24/23 indicated R6 transferred with EZ stand (Med Care) and assist of two staff. Care sheets lacked the size of harness R6 used for safe transfer. R6's lift and mobility status assessment dated 10/24/23, indicated R6 transferred with assist of two staff and EZ stand (Med Care lift). The lift harness size was not identified. R7 R7's face sheet indicated the following diagnoses acute kidney failure and weakness. R7's care plan indicated an alteration in mobility related to acute kidney injury, chronic obstructive pulmonary disease, major depressive disorder	2 830		

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2 830	Continued From page 9 and atrial fibrillation as evidenced by needing assistance with cares, dated 10/19/23. The following interventions were in place: -assist of one staff for ambulation, start date 10/19/23, -assist of one staff with movement in and out of bed, start date 10/19/23, -maximal assist of two staff for transfers, use mechanical lift stand from low surfaces. Max assist of two staff for bed mobility, does not ambulate at this time. Transfers with assist of two staff and two wheeled walker in room. Can use EZ stand (Med Care) if patient is tired in evening, start date 10/19/23. There was no mention of the harness size. Review of the facility's care sheet indicated R7 transferred with assist of two and a two wheeled walker in and R7 could use the EZ stand (Med Care) if tired in the evening. There was no mention of harness size. R7's lift and mobility assessment dated 10/17/23, indicated R7 transferred with maximal assist of two and mechanical stand per therapy recommendations. Staff to continue to monitor for safety. There was no mention of which mechanical lift or harness size to use for R7. R8 R8's face sheet indicated the following diagnoses of spondylosis without myelopathy or radiculopathy, cervical region, weakness, osteoporosis, and spinal stenosis cervical and lumbar region. R8's quarterly MDS dated 9/12/23, indicated R8 required assist with transfers and did not walk. R8 used a wheelchair. Cognition section not filled out for this assessment, previous quarterly	2 830		

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2 830	Continued From page 10 assessment dated 6/16/23, indicated intact cognition. R8 had no history of falls. R8's alteration in mobility care plan indicated R8 transferred with EZ stand (Med Care), assist of two with movement in bed and in/out of bed, dated 8/13/21. There was no mention of harness size for R8. Review of the facility's care sheet dated 10/24/23, R8 was assist of one with EZ stand (Med Care). There was no mention of harness size to use for R8. R8's record lacked a comprehensive assessment to determine which size sling/harness R8 required to ensure they were safe during these transfers. R9 R9's face sheet indicated the following diagnoses of stroke, and cervicalgia. R9's annual MDS dated 9/7/23, indicated an intact cognition and required maximal assist with transfers and did not walk. R9's alteration in mobility care plan indicated R9 transferred with assist of 1 and EZ stand (Med Care), did not ambulate, and assist of one with movement in bed and in/out of bed, start date of 10/5/20. Review of the facility's care sheet dated 10/24/23, indicated R9 transferred with EZ stand (Med Care) with assist of one staff with medium harness. Even though the facility only had large harnesses on the floor in use as a result of the observation on 10/24/23 at 4:03 p.m..	2 830		

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2 830	Continued From page 11 R9's record lacked a comprehensive assessment to determine which size sling/harness R9 required to ensure they were safe during these transfers. R10 R10's face sheet indicated the following diagnoses of weakness, and age-related disability. R10's quarterly MDS dated 8/18/23, indicated R10 was dependent on staff for transfers, no history of falls, did not walk and used a wheelchair. R10's fall risk care plan indicated R10 was assist of two staff and EZ stand (MedCare), start date 10/10/23. Transfer care plan indicated EZ stand (Med Care) and assist of one staff, dated 8/1/19. Review of the facility's care sheet dated 10/24/23, indicated R10 transferred with EZ stand and assist of two staff. Care sheet lacked what size of harness R10 needed to transfer. R10's record lacked a comprehensive assessment to determine which sling/harness size, R10 required to ensure they were safe during these transfers. During an interview on 10/25/23 at 9:31 a.m., NA-R stated staff follow the care plan/care sheets to transfer residents. NA-R looked at the care sheet and stated it did not state which harness size to use with the Med Care sit to stand lift. NA-R could not remember when she last had training on the lifts the facility used. NA-R stated the sit to stand lifts should say on the care sheet whether one or two staff needed and there are always two staff with the EZ lift.	2 830		

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2 830	Continued From page 12 During an interview on 10/25/23 at 9:39 a.m. NA-S and NA-A stated they would look at the care sheets for how to transfer any resident, if not there they would ask the nurse manager. During an interview on 10/25/23 at 12:55 p.m., speech therapist (ST)-A, director of therapy, indicated therapy does an initial assessment of new admissions for proper transfer techniques for resident. Therapy would tell nursing which type of mechanical lift to use but nursing would have to identify the sling/harness size to use as part of their nursing assessment. There is no formal assessment kept in our therapy notes for the lift they are to use, we just recommend the lift type to nursing staff. During an interview on 10/25/23 at 2:40 p.m., NA-T stated nurse managers indicated the size of harness used for the EZ stand (Med Care) and there was a chart on the EZ lift to determine what sling to use. During an interview on 10/25/23 at 2:56 p.m., licensed practical nurse (LPN-B) who was the nurse manager, stated sling/harness sizes should be in the therapy orders as therapy does the transfer assessment. If not, they would base it off resident weight in their chart and put on the care sheet. NAs could look at therapy notes as well. During an interview on 10/25/23 at 3:00 p.m., RN-C stated she would rely on the NA's as they are competent on knowing what size of sling/harness to use. RN-C would check therapy notes as therapy does an assessment when residents admitted. If residents are on the LTC side then the nurse assessment should show which size to use.	2 830		

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2 830	Continued From page 13 The facility's copy of the manufacture's operation manual, revised date 9/2010, page 9 - 11, informed reader how to operate the Med Care - Care Stand, but there was no sizing guide for harnesses even though the facility had other sizes. The facility also did not use a guide or any reference to determine harness size for each resident who used Med Care lift. Preventative Maintenance During an interview on 10/26/23 at 8:15 a.m. MM-A indicated preventative maintenance (PM) was completed monthly on all the lifts. Review of facility's form labeled, "Weekly audit for functionality for all facility lifts and stand wear/tear on slings". The form had four areas labels: stand/lift number, location, functioning properly yes/no and slings in good working condition yes/no. Under stand lift identified the stand number (Med Care) and lifts (EZ Lift). The location was identified as east, west or north wing. Functioning properly column identified a yes or no. The column slings in good working condition only identified the stands (Med Care) as yes, there were no notion if the EZ lift slings were reviewed. MM-A stated he would test the buttons of the lift so they would go up and down, tested the emergency stop button and made sure the lifts rolled well by rolling it around in a circle. MM-A was not able to articulate the manufactures recommendations for PM and did not use manufactures provided check list for PM. MM-A completed PM on 10/10/23 on all lifts per his checklist and was unsure if the lift involved in R1's incident was removed from the floor until	2 830		

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2 830	Continued From page 14 MM-A performed PM on it before returning it to the floor for use. He was unable to articulate the age of the lifts in use or other specific about the required maintenance by the manufacturer. Review of the Med Care's manufacture's operation manual model number 400002, revised 9/2010, on page 24-25 indicated the routine maintenance was a vital component to keeping the equipment in safe operating condition. A machine that is not properly maintained could create potentially hazardous situations for nursing staff and patients. Check list were to used for PM. The PM checklist had two column, pass or fail. Under general maintenance indicated the following: -Actuator and connections- check the operation of the actuator. Remove bolts and check for lithium grease. If none present, apply and re-insert. Use of a thread locker is recommended when re-attaching nut to bolt. -Actuator- check the up and down movement. If it makes noise or wobbles, it should be inspected. -Actuator cover- clean and check for wear and tear. -Base cover- clean and check for cracks and sharp edges. -Boom/arm pivot pins and bushings- check the area where the arm or boom meets the mast. Be sure the nut and bolt are securely attached. If not operating smoothly, remove bolt and apply lithium grease. Re-insert the bolt; apply thread locker, and secure nut. -Front casters- clean debris from casters and test for smooth rolling. -Hand control- check for smooth operation. -Leg covers- clean and check for sharp edges- -Leg bolts- remove base cover and check to make sure bolts are flush with the base. If not,	2 830		

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2 830	Continued From page 15 tighten. Periodically remove bolts, apply lithium grease, and re-insert using thread locker on the threads. -Leg spreader pivot bar- check the bolt on the base and make sure the nut is at least 2 threads inside the end. This nut may be adjusted to your preferred tension. -Mast/base bolts- check bolts to make sure they are re tight. If not, remove, apply thread lock and re-tighten. -Rear casters- clean and remove debris. Check to make sure the brakes are working properly and that the wheels are firmly attached. -Receiver box- clean and check for operation. Check that the on/off switch is functioning properly. Try out the toggle switch, and verify both the up and down motion of the actuator. -Batteries- check for damage to plug, and check voltage. -Slings/harness and belts- inspect slings/harness and belts for wear and tear before every use. Immediately remove any damaged slings/harness and belts from service and replace. Under the stand maintenance it indicated the following: -Foot platform- remove the platform and clean. Be sure to remove the plastic footplate cover and clean underneath. Pay attention to the plastic and check for sharp edges. -Knee pad assembly- check for tears and clean the leg strap and surface of pad. -Padded hand grips- clean hand grips, and check that they are pushed all the way on. -Arm pads- clean and check for wear and tear. -Foot pedal- check for smooth operation. In addition, the manufacture recommended replacement of the following: -Actuators to be replaced after 4 years of use	2 830		

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2 830	Continued From page 16 -Support bar on lifts replace when excessive wear is apparent -Slings to be replaced after 2 years of use. During an interview on 10/25/23 at 4:38 p.m., Med Care representative (CSR-A) stated the harness sizing was based on the resident's waist measurements. The Med Care lift, model number 400002 (the lift the facility used) were manufactured in 2009 was discontinued in 2015. All the facilities that had this lift received a Tech Bulletin identifying the manufacture would continue to supply parts for 7 years after the discontinuation date (2021). The unit should not be used longer than this date, they could not ensure the safety of the resident during transfers with these lifts. CSR-A identified Med Care's expectation is the facility would report any incident involving their equipment to them. During an interview on 10/25/23 at 1:04 p.m., DON could not state the Med Care sit to stand lift R1 fell from was removed from the floor until the next morning when MM-A inspected it. DON also stated that the facility did not have a mechanical lift policy but followed the manufactures recommendations. During a clarification interview on 10/26/23 at 8:35 a.m., DON confirmed that all Med Care harness were size large that were on the floor. Other sizes were stored in the basement and available if needed. DON was not able to identify how the harness or sling size was determined for each resident. She was also unaware the Med Care- Care Stand Total support, model number 400002 was retired in 2015 and no longer supported by the company. During an interview on 10/26/23 at 10:11 a.m., RDO and Administrator both acknowledged they did not know there was a life span to lifts or that	2 830		

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2 830	Continued From page 17 the Med Care- Care Stand Total support lift the facility was using was discontinued in 2015. Further more, they were not aware the facility did not have a system in place for harness sizing for safe transferring of residents with the Med Care-Care Stand Total support, model number 400002. During an interview on 10/26/23 at 1:37 p.m., the food and drug administration (FDA), stated the Med Care Stand, model number 400002 was no longer registered with the FDA. If the facility continued to use the unregistered device, the facility needed to have someone that supported the product to render it safe to use. The FDA further stated that if the expired device was involved in an incident that may have resulted in serious harm or death, the device would need to be reported to the FDA by the manufacturer under 42 CFR 803.3, it did not matter if the incident was caused by operator error or equipment failure. During an interview on 10/25/23 at 3:31 p.m., with EZ Way Lift representative stated the sling sizes was based on the sizing charts that are on each lift. The slings are color coded per size based on weight. The chart also explains and shows how to place the slings properly for a safe transfer of the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to slings and falls, to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be	2 830		

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2 830	Continued From page 18 developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure proper catheter cleaning and storage was provided to prevent possible urinary tract infections (UTIs) for 4 of 6 residents (R1, R3, R5 and R15) observed for catheter use. Findings included:	2 910	Corrected	12/11/23

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2 910	Continued From page 19 R1's quarterly Minimum Data Set (MDS) dated 6/8/23, identified R1 had diagnoses of neurogenic bladder (define what this is), cancer, urinary tract infections (UTI) in the last 30 days, diabetes, and stroke. R1 had an indwelling urinary catheter and was always continent of bowel. R1's bowel and bladder care plan 7/7/22 indicated R1 had altered elimination related to impaired mobility and function due to hemiplegia and hemiparesis following right sided stroke, history of UTIs, sepsis, and bladder cancer scope done on 4/3/23 that showed friable tissue over posterior bladder wall. Additionally, R1 had history of TURBT (trans urethral resection of bladder tumor) on 5/16/23 with significant hematuria (blood in urine) and indwelling urinary catheter placement. Corresponding interventions included: -Followed by urology, start date 7/722. -assist of 2 with toileting, start date 7/7/22 -provide assist with peri cares a.m., HS (bedtime) and as needed, start date 7/7/22 -monitor for signs and symptoms of UTI, start date 11/29/22, -monitor foley output, start date 8/8/23 -Foley (brand of indwelling urinary catheter) catheter care to be done twice daily with no pressure from the catheter on the tip of his penis, start date 8/8/23 Review of the facilities care guide (abbreviated care plans used by nursing assistants) dated 10/24/23, directed for the catheter to be anchored to leg at all times to avoid pulling, toilet every 2-3 hours and as needed, catheter output every shift. R1's physician orders included: -Change Foley catheter every 30 days and as needed, 16 French (Fr) 10 milliliters (ml) at	2 910		

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2 910	Continued From page 20 bedtime every 30 days make sure catheter is silicone, start date 9/22/23 -Foley catheter output three times daily, start date 9/22/23 R1's hospital discharge summaries indicted R1 had a history of UTI's with urosepsis (infection in the blood from UTI) with hospitalizations and emergency room (ER) visits from 12/30/22 through 10/24/23: -R1's hospital discharge summary dated 1/5/23, indicated R1 was admitted to the hospital on 12/30/23 with diagnoses of sepsis urinary tract infection (UTI). Lab results showed infectious bacteria found in R1's blood and urine were Staphylococcus Aureus. The summary indicated R1 was discharged from the hospital on 1/5/23, with intravenous antibiotic (IV). -R1's emergency room (ER) after visit summary dated 2/6/23, identified R1 was seen for UTI, and returned to the facility on oral antibiotics. -R1's hospital discharge summary dated 5/5/23, indicated R1 was admitted on 5/2/23 for UTI, sepsis, and confusion. R1's lab results showed infections bacteria of proteus mirabilis in urine. R1 was discharged back to the facility on 5/5/23, with oral antibiotics. -R1' hospital discharge summary dated 7/12/23, indicated R1 was admitted on 7/9/23, for altered mental status. R1's lab results showed infectious bacteria of staphylococcus Aureus from urethra wound and Escherichia coli (E. coli) and proteus mirabilis in his urine. R1 was discharged back to the facility on 7/12/23, with a Foley catheter and a midline intravenous access for IV antibiotics. -R1's hospital discharge summary dated 8/25/23, indicated R1 was admitted to the hospital on 8/23/23 for sepsis. R1's labs showed infectious bacteria E. coli in his urine. R1 was discharged back to the facility on 8/25/23, with oral	2 910		

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2 910	Continued From page 21 antibiotics. During an observation on 10/24/23 at 5:16 p.m., in R1's bathroom, there was an overnight urine collection bag sitting in a pink basin on a shelf above the toilet. The tubing connector was not capped. The bag was not dated. Above the toilet was a sign taped to the wall for Indwelling Catheter Care Procedure and Disinfection of Urinary Drainage, instructions on how to change out the legs bag and the overnight urine collection bag, as well as the cleaning instructions. At 5:20 p.m. director of nursing entered R1's bathroom, DON looked into the basin and stated the connecting tubing was not capped. DON also verified placement of sign on the wall to direct staff to disinfect drainage bags. DON then took an alcohol swab and wiped the end of the tubing and applied the blue cap, did not throw the bag away or disinfect the bag. During an observation on 10/26/23 at 8:35 a.m., had DON, RN-B and NA-M verified the bed bag was not capped or washed was sitting in the pink basin in R1's bathroom. There was also a small amount of yellow fluid present in the bag and in the bottom of the bin. NA-M stated she had not had time to return to clean the bag. When asked what the importance of capping the bed bag before placing in the clean pink bin, DON responded, to prevent contamination of the catheter bag and introducing bacteria to the resident. It was the DON's expectation the urinary collection bags were cleaned prior to being placed into the pink basin as this was a clean basin. During an interview on 10/24/23 at 4:29 p.m., FM-A stated that R1 was prone to UTI's and had been hospitalized 3-4 times this year with sepsis	2 910		

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2 910	Continued From page 22 and UTI's. FM-A stayed to visualized cares being done on R1 in the evenings and felt staff were not following their own policies for catheter care. FM-A sent pictures from her phone of the pink basin sitting on the floor in R1's bathroom with the overnight bag uncapped in the basin or the connection tubing end on the floor uncapped. R3's annual MDS dated 9/21/23, identified R3 had diagnoses of multiple sclerosis (MS) and neurogenic bladder. R3 did not have cognitive impairment. Additionally, the MDS, identified R3 did not have a catheter and was frequently incontinent of bladder and always continent of bowel. R3's physician orders included the following: -Foley output every shift for catheter, start date 10/2/23 -Place foley catheter 16 Fr with 10 milliliters (ml's) balloon. Change on 2nd of every month and as needed (PRN) for overflow incontinence, start date 10/2/23. R3's bowel and bladder care plan dated 4/17/2018, indicated R3 had altered elimination related to diagnoses of MS, weakness, and flaccid neurogenic bladder. Corresponding interventions included: -Straight cath as needed for inability to void or empty bladder fully, start date 3/5/2020. -Total assist of 2 via full body mechanical lift for toileting every 2-3 hours and as needed, start date 4/17/18. -Monitor and report for signs and symptoms for UTI, start date 4/17/2018. In review of R3's care plan, it was not evident the care plan was revised to include goals and interventions for the care of the indwelling urinary	2 910		

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2 910	Continued From page 23 catheter. Additionally, R3's nursing assistant care guide did not identify R3 required an indwelling catheter. During an observation and interview on 10/26/23 at 8:46 a.m., R3 was sitting in electric wheelchair with a bed bag hooked on the bottom of the wheelchair. The bag was dated 10/12/23. There was a milky white liquid substance in the tubing and a white flaky substance on the walls of the tubing. The catheter was not secured to either of R3's legs. R3 stated that at times that "bed bag [overnight collection]" got caught on her wheels and the bag popped. This pulls on the tubing but has not pulled out the foley catheter. RN-B confirmed that the catheter bag should be changed weekly on bath days and that there was sediment built up in the tubing. R5 R5's 5-day MDS dated 10/19/23, indicated intact cognition with diagnoses of sepsis with septic shock, UTI in the past 30 days, benign prostatic hyperplasia (BPH)and urinary retention. R5 had an indwelling catheter and was always incontinent of bowel. R5's physician orders included the following: -change foley catheter (16fr with 10 ml's balloon) monthly and as needed. One time a day starting on the 1st and ending on the 1st each month for foley catheter cares, start date 10/24/23, -change foley/suprapubic catheter bag on hsower day in the morning every Tuesday, start date 10/20/23, -change graduate used for catheter output weekly, in the morning every Tuesday. R5's 10/24/23 care plan indicated alteration in elimination related to BPH with lower UTI	2 910		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 24 symptoms. The following intervention were in place: -monitor foley catheter output, start date 10/24/23, -change foley catheter per policy, start date 10/24/23, -foley catheter care per policy. During an observation on 10/26/23 at 8:13 a.m. R5 sat in his recliner, his catheter bag dated 10/18/23, was lying on the floor next to the chair. R15 R15's 5-day MDS dated 9/8/23, indicated an intact cognition and diagnoses of cerebral palsy and BPH. R15 had an indwelling catheter and was always continent of bowel. R15's physician orders included the following: -change foley/suprapubic catheter bag on shower day, in the morning every Monday, start date 9/2/23, -change graduate used for catheter output weekly, one time a day every Monday, start date 9/2/23, -monitor catheter ourput every shift, start date 9/2/23. R15's 9/8/23 care plan indicated no alteration in elimination as R15 is continent of bowel. There following interventions were in place: -monitor foley catheter output, start date 9/8/23, -change foley catheter per policy, start date 9/8/23, -foley catheter care per policy. During an observation on 10/26/23 at 8:24 a.m., R15 had a catheter bag dated 10/16/23. Foley was secured to his left leg with an undated device.	2 910		

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2 910	Continued From page 25 During an interview on 10/26/23 at 8:56 a.m., registered nurse (RN)-B stated catheter cares was the responsibility of the NA taking care of the resident. There was no place found on the MAR/TAR for nursing to sign off on catheter cares, just the changing out of the catheter itself on a monthly basis. During an interview on 10/27/23 at 9:31 a.m., nurse manager (NM)-A stated the nursing assistants (NAs) trade out the overnight bags to the leg bags when the resident was out of bed, NAs would then wash out the bags with vinegar, hang to dry, and then place them into a pink basin. The process of changing out the bags was completed per resident's preference and the bags were changed out weekly on the resident's bath day. NM-A reviewed the facility policy and indicated step 5 to uncap bottom outlet of bag, drain urine into measuring container, then recap outlet. NM-A stated wiping the outlet with an alcohol wipe prior to re inserting or closing the outlet should be part of the process. NM-A stated this voided step could lead to the introduction of bacteria/infection to the resident. During an interview on 10/25/23 at 5:17 p.m., DON stated it was her expectation staff complete catheter cares as the policy procedure stated. Recently has done one on one training with all staff. Review of the facilities policy Disinfection of Urinary Drainage Bag indicated should be completed daily when the urinary drainage bag was removed from the resident to leg bag and vice versa with the following steps: 5. uncap bottom outlet of bag, drain urine into measuring container, then recap the outlet.	2 910		

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2 910	Continued From page 26 (Should be wiped with alcohol prior to recapping per NM-A interview on 10/27/23.) 16. Remove top cap. Partially fill the bag with 55-65 millimeters (ml's) of vinegar. 17. Shake the bag gently so the entire inside is rinsed well. 18. Drain vinegar from bag, store bag on clean towel or in clear plastic bag until next use; allowing exterior to air dry. 20. Change out bag for a new appliance on bath day. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders for residents with catheters to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		