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	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaklawn Care & Rehabilitation Center	201 Oaklawn Avenue Mankato, MN 56001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a comprehensive care plan for diabetic management that included goals and individualized interventions was developed or 1 of 3 residents (R2) reviewed for care plans.Findings include:R2's face sheet dated 2/27/26, identified diagnoses of type 2 diabetes with hyperglycemia.R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had no cognitive deficits, was on a therapeutic diet, and took hypoglycemic medications (used to lower blood glucose).R2's medication administration record (MAR) for January 2026, identified an order from 9/12/24, that was for a FreeStyle Libre 2 Sensor continuous blood glucose monitoring system sensor to be applied every 14 days.R2's care plan current at the time of survey included R2's diagnosis of diabetes as a related factor of the focus which included (but not limited to) falls, vulnerable adult, nutrition, skin integrity, however, R2's care plan did not include diabetic focus that identified R2's blood glucose range goals, use of the continuous blood glucose monitoring system, interventions for responding to high or low blood glucose levels, or monitoring and reporting parameters for abnormal glucose readings. The care plan also did not include individualized interventions related to R2's hypoglycemic medications or monitoring for signs and symptoms of hyperglycemia or hypoglycemia.R2's blood glucose readings were reviewed between 1/1/26 through 2/27/26 in conjunction with progress notes and MAR documentation. The blood glucose record identified low blood glucose readings but there was no documentation indicating R2 was assessed for sign/symptoms and monitored for signs/symptoms of hypoglycemia in addition to timely rechecks of blood glucose, and no documentation of intervention to raise R2's blood sugar. Examples included: -1/3/26 at 8:44 a.m. of 53mg/dl, no subsequent checks until 12:09 p.m. when it was 75 mg/dl.-1/13/26 at 7:12 a.m. of 68, not checked again until 12:45 p.m.-1/15/26 at 9:17 a.m. and 11:21 a.m. both at 70.-2/22/26 at 10:09 a.m. 59 with no recheck until 1:45 p.m.During an interview on 2/27/26 at 12:53 p.m., licensed practical nurse (LPN)-B, who is the care coordinator, stated acceptable blood glucose ranges would range from 80-110 or 90-120. Low range would be below 70 or 80. LPN-B would consider anything above 150 high. R2's blood glucose goes low frequently and that was why the continuous glucose monitor was kept by her. The continuous glucose monitor would beep if the blood glucose was running low or high and an arrow would point either up or down showing which way the blood glucose was going. Blood glucose should be checked 30 minutes to an hour after interventions of a small glass of orange juice or protein, typically something with peanut butter was given. Low and high ranges should be passed on in shift report, so the oncoming nurse was aware. Provider would not be notified if the blood glucose was able to go up after interventions but if it was not working, the provider should be notified. Standing orders identify that glucagon should be given, and provider notified if blood glucose is less than 60 and higher than 500. LPN-B expected that nurses would check blood glucose more frequently if the numbers were low and follow protocol. During a subsequent interview on 2/27/26 at 1:26 p.m., LPN-B reviewed R2's care plan and could not find anything specific to diabetic management for staff to follow.During an interview on 3/3/26 at 4:13 p.m., director of nursing (DON) stated care plans are updated with significant change and reviewed (continued on next page)

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.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quarterly with MDS. Care plans should include diabetic management.The facility Care Planning policy reviewed 11/2024, identified the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Care plan shall be used in developing the residents daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff implemented proper peri care techniques, including use of Enhanced Barrier Precautions (EBP), appropriate glove changes, and hand hygiene, to prevent or mitigate the risk of urinary tract infections for 2 of 2 residents (R2, R4) reviewed for peri care.Findings include:Findings include:R2's face sheet dated 2/27/26, identified diagnoses of cystitis without hematuria (bladder infection commonly caused by Escherichia coli (commonly entered into the urinary tract through contamination of feces), neuromuscular dysfunction of the bladder (nerve damage impairs bladder control), and personal history of urinary tract infections (UTI).R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had no cognitive deficits, dependent on staff for toileting needs, resident had a urinary catheter with occasional bowel incontinence.R2's care plan dated 4/19/24, identified Enhanced Barrier Precautions (EBP) related to indwelling foley catheter. Interventions included staff to follow EBP, use appropriate communication to follow EBP, explain reason for use of EBP, staff to put on/take of personal protective equipment (PPE) per EBP when providing high contact cares.R2's nursing order dated 4/11/25, identified staff to follow EBP while providing urinary catheter maintenance, contact with the catheter, tubing, collection bag, and other high contact care activities.R2's care plan dated 8/29/23, identified alteration in elimination related to inability to urinate independently, diarrhea as evidenced by foley catheter and occasional incontinence of bowel. Interventions included assist of two with toileting every 2-3 hours and as needed, provide assistance with peri-cares AM, HS (bedtime) and as needed, provide incontinent products and assist to change as needed, monitor skin integrity, monitor for signs/symptoms of UTI, diagnosis of diabetes increases risk for UTI.R2's nursing assistant care sheet undated, identified CONTACT PRECAUTIONS: DIARRHEA AND INDWELLING FOLEY CATHETERR2's nursing order dated 2/3/26, directed staff to encourage increased oral fluid intake as tolerated, provide perineal care frequently, keep peri-area clean and dry to reduce bacterial growth. Additionally, monitor and chart for signs/symptoms of UTI: dysuria (pain or discomfort with urinating), frequency, urgency, supra-pubic discomfort, foul smelling or cloudy urine, hematuria (blood in urine), or new confusion/behavior changes.R2's progress notes from 2/4/26-2/7/26, identified R2 had amber colored urine with a foul odor, Physician was notified and instructed to increase fluid intake and call back if symptoms worsened or if UTI symptoms were noted. R2 continued to have amber colored urine and provider was notified again on 2/7/26 and recommended to continue monitoring and report any changes to provider.R2 was hospitalized from [DATE]-[DATE], for a fall.R2's Hospital Discharge summary dated [DATE], identified urinalysis was attempted but initially unable to be processed due to hematuria and purulent material; repeat collection showed evidence for UTI and R2 was started on intravenous (IV) ceftriaxone (antibiotic).R2's progress note dated 2/19/26, identified R2 complained of pressure down there.During a continuous observation on 2/26/26 from 2:21 p.m. to 3:25 p.m. R2 had an EBP sign on her door that directed the usage of gown and gloves. R2 was in her room, lying in bed. Nursing assistant in training (NA)-A was in the room with gown on cleaning R2, after R2 had an incontinent loose stool. NA-A completed peri cares and placed a new brief on R2. NA-A removed gloves and applied a new pair without sanitizing hands. NA-A removed mechanical lift sling from behind R2, tied trash bag with incontinent material from garbage can, moved cellphone from overbed table, lowered bed, removed gloves and then sanitized hands. NA-A removed the garbage from the can and left the room. At 3:05 p.m., NA-B entered the room without EBP and R2 stated she had diarrhea and needed changed. NA-B did not wash hands before putting on gloves and did not put on a gown. NA-B lifted the bed with the remote to a higher level. NA-B removed tabs from R2's brief and folded the brief between R2's legs. Dark brown liquid stool was pooled over R2's vagina and up into her abdominal folds. R2 had both a disposable and cloth pad under her in which liquid stool had seeped (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	onto both pads. Stool went onto NA-B's gloved hand while she was cleaning it. Then NA-B touched R2's left thigh with the glove contaminated with stool which left an outline of stool on her leg. NA-B cleaned the stool from R2's thigh with a wipe. R2 did not change gloves and sanitize hands. NA-B rolled both pads toward the middle of R2's back so R2 could be rolled over the soiled pads and they could be removed from the opposite side while placing a clean pad underneath in the same position. During the care, R2 stated, Don't be surprised if we get all changed and I have it again. Once the clean pad was placed under R2, NA-B began wiping stool from around the vaginal folds and the catheter area. NA-B did not change gloves or perform hand hygiene prior to providing this care. While cleaning the area, NA-B wiped the catheter toward the vaginal area. The end of the catheter tubing closest to the meatal surface appeared very dark in color compared to the portion of tubing farther away, which was light yellow. NA-B continued wiping stool toward the vaginal area using wet wipes. NA-B then applied powder under R2's abdominal fold without changing gloves or performing hand hygiene. Afterward, NA-B repositioned the brief and pulled it up in the front. NA-B returned the container of wet wipes to a drawer and stated she was going to look for another pad. While still wearing the same gloves, NA-B opened cupboards in R2's room and moved items around while searching. NA-B then took R2's call lights and attached them to her blanket. NA-B removed the used garbage bag from the trash can and placed a new bag in the can. NA-B then left the room carrying the garbage and dirty linens while continuing to wear the same gloves and stated she would be right back.During an interview and observation on 2/26/26 at 3:26 p.m., registered nurse. RN-A entered R2's room without putting on gown and gloves RN-A took a stethoscope and listened to R2's abdomen at all four quadrants without wearing EBP. RN-A placed a blood pressure cuff on R2's right arm and got a reading. RN-A placed cuff on R2's left arm and stated the blood pressure was still a little low and that she was going to get a manual cuff to check it. RN-A left the room and returned with a manual cuff. RN-A did not put on EBP. RN-A stated EBP should be worn if a resident has a catheter, and there would be a sign on the door explaining when to wear EBP. RN-A stated anytime gloves are soiled they should be changed and hand hygiene should be done between glove changes.R4R4's face sheet dated 3/3/26, identified hemiplegia affecting left nondominant side.R4's comprehensive MDS dated [DATE], indicated R4 did not have cognitive impairment. R4 was frequently incontinent of urine and always incontinent of bowels.R4's care plan dated 4/6/21, identified R4 was incontinent of bowel and bladder. Interventions included assist of one with peri cares AM, HS (before bed), and as needed.During an observation on 2/27/26 at 7:38 a.m., R4 was in bed. R4 stated she had a bowel movement. NA-D applied gloves then wiped R4's bottom that had stool on it, and removed the soiled brief. NA-D did not remove gloves and perform hand hygiene before she obtained a new brief from R4's drawer. NA-D then had roll towards the wall and touched R4's shirt with dirty gloves. R4 rolled onto her back. NA-D took a wipe and applied Tena cream. NA-D used the wipe and wiped R4's inner thighs and around vaginal area back to front, front to back, and under abdominal fold. NA-D took another wipe from the container, and wiped the same areas again. NA-D placed a new brief on R4. NA-D removed gloves but did perform hand hygiene before she removed two clean shirts from R4's closet. NA-D gave R4 choices for which one to wear and put the other one back in the closet. NA-D continued to dress R4 and transferred R4 to the wheelchair. NA-D then removed her gloves and sanitized hands when she was leaving the room with R4.During an interview on 2/27/26 at 10:15 a.m., RN-B indicated she did not complete audits or supervise NA's to ensure proper peri care was completed to reduce the risk of UTIs. During an interview on 2/27/26 at 12:53 p.m., licensed practical nurse (LPN)-B, who is the care coordinator, indicated she did not complete audits or supervise NA's to ensure proper peri care was completed to reduce the risk of UTIs. During an interview on 3/3/26 at 4:13 p.m., director of nursing (DON), who also is the facility Infection Preventionist (IP) stated she has not identified any trends with UTI's at the facility. Residents are to the emergency room and diagnosed with UTI. DON does not get a UA/UC report from the hospital and has not went online and attempted to get the information. DON would audit if an issue was noted such as multiple UTI's on the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	same wing or a concern of peri cares not being done correctly. Females should always be wiped front to back. Gloves should always be changed when soiled, after finishing, and handwashing/sanitizing completed before putting on or after removing gloves. EBP should be used on anyone with medical devices.The facility Catheter Care policy dated 11/2019, identified a step-by-step guide to performing catheter care. 2. Wash hands and apply gloves. 6. Wipe downward away from urethral opening. 7. Wash genital area from front to back. 11. Remove gloves and wash hands.The facility Infection Prevention and Control Program policy dated 11/2024, identified surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. Important facets of infection prevention include educating staff and ensuring that they adhere to proper techniques and procedures, implementing appropriate isolation precautions when necessary; and following established general and disease-specific guidelines