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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaklawn Health Care, LLC	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the consultant pharmacist identified and reported a medication irregularity during the required monthly drug regimen review for 1 of 1 residents (R1), when an unauthorized Haloperidol order remained active despite the resident's diagnoses of epilepsy and Parkinsonism. This failure resulted in the medication remaining on the resident's medication regimen from March through June 2026 without identification during the required monthly pharmacist reviews.R1's face sheet dated 6/17/26, identified diagnoses of localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures not intractable without status epilepticus (abnormal electrical activity begins in a specific area of the brain rather than the entire brain, hallucinations, and parkinsonism (condition that affects movement). R1's Medication Administration Record (MAR) dated 3/2026, identified an order for Haloperidol Lactate oral concentration (Haldol) 2 milligrams (mg)/milliliter (mL). Give 1.5 mL by mouth at bedtime for terminal agitation. Start 3/13/26 at 7:00 p.m. Review of R1's record identified no corresponding physician order to begin Haloperidol Lactate between 3/2026-6/2026 had been prescribed to R1. No corresponding progress note identifying the order or that a physician prescribed it. R1's MAR's for 3/2026, 4/2026, 5/2026, and 6/2026, identified that Haldol was given every evening beginning on 3/13/26 through 6/9/26. R1's Extended Care Visit Note dated 3/23/26, identified current orders reviewed which included Haldol 1.5 mL at bedtime. Additionally, R1 was seen by and current orders reviewed and signed which included the Haldol 1.5 mL at bedtime on 4/22/26, and 5/11/26. Hospice Current Plan of Care dated 3/26/26, did not identify a current order for Haloperidol. However, under additional services which was a capitulation of R1's record with hospice, it identified to discontinue all Haldol orders on 1/28/26. Additionally, the Hospice Current Plan of Care completed on 4/23/26, 5/7/26, 5/21/26, and 6/4/26, did not identify the order for Haldol that began on 3/13/26. R1's pharmacy recommendations dated 5/20/26, identified a recommendation that Haloperidol 2mg/mL (1.5 mL) is currently ordered nightly for agitation. Consider changing the order to as needed and discontinue if not used. During a return telephone interview on 6/24/26 at 9:16 a.m., consultant pharmacist (CP)-A stated she reviewed all current residents' medications once a month. CP-A stated she reviewed each resident's current medication list and certain medications should be monitored more closely, including psychotropics, medications requiring laboratory monitoring, and as needed antipsychotics. CP-A stated she reviewed her April recommendations for R1 and did not make any notes regarding Haldol and was uncertain why she did not. CP-A acknowledged she made a recommendation in May to change the medication to as needed and discontinue. During a telephone interview on 6/18/26 at 11:56 a.m., pharmacist (Ph)-B stated monthly drug regimen reviews are completed by the consultant pharmacist. Ph-B stated if she had completed the April review, she may have flagged the Haldol because of the resident's Parkinsonism and epilepsy. Ph-B stated antipsychotics are warned against for patients with Parkinsonism and epilepsy and if this represented a starting dose for Haldol it would be considered high for someone naive to the medication or who had been off the medication for some time. The pharmacy Consultant Pharmacist Services Provider Requirements dated 5/2022 identified regular and reliable consultant pharmacist services are (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided to residents. The consultant pharmacist is responsible for identifying and evaluating medication-related issues, including prevention and reporting of medication errors, identifying contraindications, side effects and adverse effects, completing a monthly medication regimen review, communicating potential or actual medication-related problems to the responsible prescriber and facility leadership, reviewing medication administration records and physician orders at least monthly, and documenting resident-specific recommendations in the resident's active record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 1 residents (R1) was free from a significant medication error when Haloperidol was entered into the facility's integrated electronic medication ordering system and administered to R1 from 3/13/26 through 6/9/26 without a valid and verified physician order.Findings include:The Nursing Home Incident Report (NHIR) submitted to the State Agency (SA) identified Haloperidol order intended for another resident was inadvertently entered into R1's chart. Medication was administered until review following seizure activity and discontinued upon discovery.R1's face sheet dated 6/17/26, identified diagnoses of localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures not intractable without status epilepticus (abnormal electrical activity begins in a specific area of the brain rather than the entire brain, hallucinations, and parkinsonism (condition that affects movement).R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had severe memory issues, no hearing issues and wore glasses, required some assistance with activities of daily living. R1 was taking antipsychotic medication on a regular basis with no gradual dose reduction attempted.R1's care plan dated 6/17/26 identified R1 had a seizure disorder with diagnosis of localization related symptomatic epilepsy with complex partial seizures and recent seizure activity. Interventions included: ensure a position to prevent injury during seizure activity, ensure open airway and document characteristics of seizure; monitor neurological status after any activity for residual impairment; notify medical doctor (MD) of any seizure activity; provide privacy and dignity during seizure activity; seizure medication management by hospice provider with scheduled and as needed Lorazepam; seizure medications will be administered as ordered, monitor for effect and side effects.R1's Pharmacist Recommendation dated 3/11/26, identified a pharmacy recommendation for Lorazepam. Handwritten note of prescribers response patient with high-risk seizure disorder-needs to have and signed by MD-A.R1's Medication Administration Record (MAR) dated 3/2026, identified an order for Haloperidol Lactate oral concentration (Haldol) 2 milligrams (mg)/milliliter (mL). Give 1.5 mL by mouth at bedtime for agitation. Start 3/13/26 at 7:00 p.m. with a discontinued date of 3/13/26 at 12:20 p.m. A second order Haloperidol Lactate oral concentration 2 mg/mL. Give 1.5 mL by mouth at bedtime for terminal agitation. Start 3/13/26 at 7:00 p.m.Review of R1's record identified no corresponding physician order to begin Haloperidol Lactate between 3/2026-6/2026 had been prescribed to R1. No corresponding progress note identifying the order or that a physician prescribed it.Review of R1's MAR's for 3/2026, 4/2026, 5/2026, and 6/2026, identified R1 was administered Haldol every evening from 3/13/26-6/9/26.During a telephone interview on 6/17/26 at 11:36 a.m., licensed practical nurse (LPN)-A stated on 3/12/26, she recalled going through orders for R1 and thought she took the Haldol order out of the system and put it back in the system. LPN-A recalled it was a hospice order. While transcribing it, she had gotten up from the computer and went to the medication cart to verify the strength. R1 still had a bottle of Haldol in the medication drawer from a prior order. LPN-A had not been aware that orders put in the electronic record go straight to the pharmacy to be filled. LPN-A could not recall if there was an order for a different resident and she transcribed it in R1's chart or how she ended up putting the order in R1's electronic record.During a telephone interview on 6/17/26 at 11:30 a.m., pharmacy technician (PhT)-A stated the facility was integrated with the pharmacy to directly fill the orders that were transcribed into the electronic health record. If the order was in the system, the facility did not have to send the pharmacy confirmation of order with a doctor signature. There was no way for pharmacy to verify the order written was correct. When the order was written in the electronic system a provider name had to be attached to the order. PhT-A was aware the electronic system allowed for any provider name to be attached to the order.R1's Extended Care Visit Note dated 3/23/26, identified current orders reviewed which included Haldol 1.5 mL at bedtime. Additionally, R1 was seen by and current orders reviewed and signed which (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included the Haldol 1.5 mL at bedtime on 4/22/26, and 5/11/26.Hospice Current Plan of Care dated 3/26/26, did not identify a current order for Haloperidol. However, under additional services which was a capitulation of R1's record with hospice, it identified to discontinue all Haldol orders on 1/28/26. Additionally, the Hospice Current Plan of Cares completed on 4/23/26, 5/7/26, 5/21/26, and 6/4/26, did not identify the order for Haldol that began 3/13/26.R1's progress note dated 4/22/26, identified R1 had an episode with full body tremors, stiffness in legs, arms, and hands accompanied by a blank stare.R1's pharmacy recommendations dated 5/20/26, identified a recommendation that Haloperidol 2mg/mL (1.5 mL) is currently ordered nightly for agitation. Consider changing the order to as needed and discontinue if not used.During a telephone interview on 6/18/26 at 11:56 a.m., pharmacist (Ph)-B stated drug regimen reviews are completed monthly on all residents by the consultant pharmacist (CP)-A. Ph-B stated if she had done the review in April she may have flagged the Haldol for Parkinsons and epilepsy but if the patient was doing well and did not have seizures or worsening motor issues she may not have flagged the medication. Ph-B stated antipsychotics are warned against for patients with Parkinsons and epilepsy. If that was a starting dose for Haldol, it would be considered high for someone that was naive to the medication or had been off of it for awhile.During a return telephone interview on 6/24/26 at 9:16 a.m., from a call on 6/18/26 at 11:26 a.m. when consultant pharmacist (CP)-A was not near a computer stated she reviewed all current residents medications once a month that are at the facility. CP-A would look at residents current medication list. Certain medications should be monitored more such as psychotropics, medications that require lab monitoring, and as needed antipsychotics. CP-A reviewed her recommendations for R1 in April and stated she did not make any notes about Haldol and was uncertain why she did not but did make a note on the May recommendation to change to as needed and discontinue.R1's Extended Care Visit Note dated 6/8/26, identified to discuss with hospice regarding Haldol use at bedtime to see if this could be tapered to 1 mL since there are no recent reports of agitation at bedtime.R1's record identified on 6/8/26, the pharmacy recommendation was reviewed by nurse practitioner (NP)-A with recommendation to discuss with hospice because hospice prescribed this medication.R1's progress note dated 6/9/26, identified at noon R1 was observed having a seizure. During seizure, R1 was gasping for air with very loud (snore-like) breathing. Following the seizure, R1 was very tired.R1's physician order dated 6/9/26, identified discontinue Haldol.During an interview on 6/17/26 at 8:42 a.m., registered nurse (RN)-A stated R1 had recently had three seizures. RN-A stated R1 had two seizures during the night on 6/9/26, and then the one at noon that she charted about. RN-A stated the seizure lasted approximately five minutes after she was in the room with R1. R1 had a hard time coming out of the seizure. Reviewed R1's Haldol order from 3/13/26, RN-A stated it was put in the system by LPN-A. RN-A could not locate an order that had been prescribed by a physician for the Haldol in the computer. RN-A was unsure how the bottle of Haldol could have come from the pharmacy without an actual order for it.During an interview on 6/17/26 at 3:46 p.m., nurse managers (NM)-A and B stated they were unaware that facility was integrated with pharmacy and that pharmacy could fill orders based off the order put in the system without a physical copy sent to them.During an interview on 6/17/26 at 9:06 a.m., Administrator stated regional nurse consultant (RNC)-A completed the investigation of the incident and believed the medication was intended for R2.During an interview on 6/17/26 at 9:18 a.m., RNC-A stated R2 had an order to discontinue Haldol when Ativan arrived and LPN-A had put that order in about the same time the order for R1 was written. The pharmacy is integrated with the electronic record and when an order is put in electronically the order is automatically transmitted to the pharmacy. Pharmacy can fill the order and send to facility without an actual physical order present unless it is a controlled drug, Intravenous medication, new admissions, hospital returns, or if the number of characters is too big in the order we put in. The facility had a safeguard in place for when the Health Unit Coordinator (HUC) placed orders in the electronic record that required a nurse to verify the order was correct prior to the order being live in the system. Medical doctor (MD)-A discontinued the Haldol for R1 because it lowers the seizure threshold. At (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:20 a.m., RNC-A stated pharmacy recommendations are reviewed on routine rounds with clinics on resident scheduled visits unless it was an urgent recommendation that needed to be addressed immediately.During an interview on 6/18/26 at 12:40 p.m., RNC-A stated facility, primary care providers, and hospice should be reviewing the residents charts to ensure accuracy.During a telephone interview on 6/18/26 at 11:06 a.m., hospice clinical director (CD)-A stated hospice should complete a medication reconciliation upon admission, every six months, and with medication changes hospice initiated. Routinely, and at a minimum every couple of weeks, hospice nurse should compare medication list with facility medication list to make sure they match. CD-A reviewed hospice records for R1. Hospice did not have any notes about medication reconciliation being completed in March, April, or May. In June, there was a note that facility was completing an internal investigation on Haldol medication that had been given to R1 since March. Knowledge and training of RN's and physicians should be that we check for Parkinsonism and history of seizures in patients.During a telephone interview on 6/17/26 at 3:09 p.m., pharmacist (Ph)-A stated Haldol 1.5 mL was three time the normal starting dose. Ph-A stated if R1 already had a history of seizures she could not say if this error would cause more seizures necessarily. Ph-A stated that based on the dose this would be considered a significant medication error.During a telephone interview on 6/18/26 at 9:36 a.m., medical doctor (MD)-A stated she discontinued the Haldol because it was not an appropriate medication for R1's diagnoses.During a telephone interview on 6/17/26 at 3:18 p.m., MD-A stated R1 had seizures and every time a person has a seizure there is neurological harm. Haldol is not advised in patients with seizure disorder as it lowers the seizure threshold or Parkinsons. Seizures/Parkinsonism could cause a lot of freezing with muscle issues. MD-A could not say with 100% certainty that R1's Haldol usage caused the seizure but the fact that we put him at any risk is not good. I just feel like he kind of got double whammied with the whole thing. MD-A was frustrated because the facility put the order under her name and she absolutely did not give the order.The facility Medication and Treatment Orders policy dated 2/2024, identified orders must be recorded on th Physicians Order Sheet in the residents chart. Such orders are reviewed by the consultant pharmacist. Orders for medications will be transcribed in a timely manner.The pharmacy Consultant Pharmacist Services Provider Requirements dated 5/2022, identified regular and reliable consultant pharmacist services are provided to residents. Assists with identification and evaluation of medication-related issues, including prevention and reporting of medication errors. Identifying one or more current medication references to facilitate the identification of medications and information on contraindications, side effects and/or adverse effects. Completing a monthly medication regimen review, communicating to responsible prescriber and facility leadership potential or actual problems detected and other findings related to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well a regulatory compliance issues. Reviewing medication administration records and physician orders at least monthly to ensure proper documentation of medication orders and administration to residents. Resident specific recommendations are documented in the residents active record.The facility Hospice policy dated 11/2023, identified it is the responsibility of the hospice agency to coordinate residents care as it relates to terminal illness and related conditions. It is the responsibility of facility staff to notify the hospice provider and primary care provider about significant change in condition or situations requiring a revision of the plan of care.The Physician Visits policy dated 8/2024, identified the attending physician must perform relevant tasks at the time of each visit, including a review of the residents total program of care and appropriate documentation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to remove discontinued medications from the active medication storage for 2 of 2 residents (R3, R4) creating the potential for inadvertent medication administration. Findings include: R3During an observation and interview on 6/17/26 at 12:36 p.m., Registered nurse (RN)-A opened the medication cart and went to R3's medication section. RN-A observed R3's Lidocaine patches and Quetiapine Fumarate (Seroquel) remained in the medication cart. RN-A reviewed R3's current medication orders and stated there was not a current order for Seroquel or Lidocaine patches. RN-A removed the medications from the medication cart and stated medications should be removed from the medication cart right away after the order was discontinued to avoid medication errors. RN-A stated it was basic nursing knowledge to remove discontinued medications from the medication cart. R3's face sheet dated 6/17/26, identified diagnoses of fracture of one right rib, other chronic pain, agoraphobia with panic disorder, and generalized anxiety disorder.R3's physician visit dated 6/8/26, identified an order to discontinue Quetiapine Fumarate (Seroquel) 25 milligram (mg) oral tablet.R3's progress note dated 6/8/26, identified nurse practitioner (NP) visited resident today with new orders given. NP would follow-up in one week.R3's physician visit dated 6/15/26, identified an order to discontinue lidocaine 4% external patch and the same order to discontinue Quetiapine Fumarate 25 mg as ordered on 6/8/26.R3's progress note dated 6/16/26, identified R3 was seen on rounds by NP. Orders to discontinue lidocaine patch for non-use, and discontinue Seroquel.R3's medication administration record (MAR) dated 6/2026, identified Quetiapine Fumarate was administered daily from 6/1/26-6/15/26. The Lidocaine patch was marked as 2-drug refused from 6/1/26-6/15/26.During an interview on 6/17/26 at 1:03 p.m., RN-B stated she reviewed physician dictation on 6/16/26, while working the night shift. RN-B stated she would remove the order from the electronic medical record, enter a progress note, and then remove the discontinued medication from the medication cart. RN-B stated she forgot to remove the medications after discontinuing the orders in the electronic system.R4During the observation and interview on 6/17/26 at 12:36 p.m., RN-A opened the medication cart and went to R4's medication section. RN-A observed Amlodipine remained in the medication cart after the medication had been discontinued. RN-A removed the medication from the medication cart.R4's face sheet dated 6/17/26, identified a diagnosis of essential (primary) hypertension.R4's progress note date 6/15/26, identified R4 was seen by physician on 6/11/26. Orders to discontinue Amlodipine 5 mg received.R4's MAR dated 6/2026, identified Amlodipine Besylate 5mg was provided to R4 from 6/1/26-6/15/26.During an interview nurse manager (NM)-B stated after discontinuing a medication it should be removed from the medication cart. NM-B would occasionally go through the medication carts and remove ones she was aware had been discontinued. Nurses are expected to pull discontinued medications when the order is discontinued.During an interview on 6/18/26 at 12:40 p.m., regional nurse consultant (RNC)-A stated she expected medications that were discontinued to be removed from the medication cart within a reasonable amount of time between five minutes to one hour after discontinuing the order. Not doing that could lead to potential medications errors and inadvertent administration.During a telephone interview on 6/18/26 at 9:36 a.m., medical doctor (MD)-A stated she expected the facility to review the entire dictation when it was sent to them so they are aware of all order changes.The facility Discontinuation of Medications policy dated 5/2022, identified medication are removed from the medication cart or active supply immediately upon receipt of an order to discontinue to avoid inadvertent administration.