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	04/16/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview, and record review the facility failed to ensure professional standards of practice were followed during administration of eye drops for 3 of 3 residents (R12, R15, R106) observed for medication administration. Findings include: R12's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R12 was cognitively intact, no rejection of care, required, maximal assistance with personal hygiene, and diagnoses included progressive neurological conditions, hemiplegia or hemiparesis (weakness or partial paralysis on one side of the body), and multiple sclerosis (central nervous system autoimmune condition. Damage to myelin causes symptoms like muscle weakness and vision changes) . R12's care plan dated on 4/1/25, did not indicate any care needs related to her eyes. R12's medication review report printed 4/15/25, indicated Artificial Tears Ophthalmic Solution 1-0.3% (Propylene Glycol-Glycerin) instill one drop in left eye three times a day for dry eye and instill two drop in right eye as needed for as needed for dry eyes. R15's quarterly MDS dated [DATE], indicated R15 had moderately impaired cognition, no rejection of care, dependent on staff for personal hygiene and diagnosis included hemiplegia or hemiparesis. R15's care plan dated on 4/1/25, did not indicate any care needs related to her eyes. R15's medication review report printed 4/15/25, indicated Refresh Plus Ophthalmic Solution (Carboxymethylcellulose Sodium) instill one drop in both eyes four times a day for red puffy eyes. On 4/14/25 at 7:05 p.m., R15 was laying in bed and registered nurse (RN)-C placed gloves on both and explained to R15 she was administering her eye drops. RN-C placed the tip of the eye drop bottle at the inner corner of each eye to instill the drops. RN-C was not observed to pull down either lower eye lid to administer the eye drop in the pocket of the lower eye lid. On 4/14/25 at 7:23 p.m., RN-C stated the correct technique for eye drop administration included pulling the lower eye lid down and creating a pocket of the lower eye lid to place the eye drop. RN-C confirmed during R15's eye drop administration she did not pull the lower eye lid down to create a pocket. (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

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	04/16/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 8:08 a.m., R12 was laying in bed and trained medication aide (TMA)-A stated she had R12's eye drops. TMA-A placed gloves on both hands and placed the tip of the eye drop bottle at the inner corner of each eye to instill drops. A drop was observed to run down R12's right side of her face. TMA-A was not observed to administer the eye drop in the pocket of the lower eye lids or attempt to place the drop in the pocket of the lower lid. On 4/15/25 at 8:47 a.m., TMA-A confirmed she administered R12's eye drops without pulling down the lower lids, and stated the correct administration for eye drops was to pull down the lower lid of the eye. TMA-A stated R12 does not like when we touch her face. On 4/15/25 at 8:50 a.m., R12 stated she would not care if staff touched her eye lids when administering eye drops if staff wore gloves. On 4/15/25 at 8:57 a.m.,, licensed practical nurse (LPN)-B, known as the care coordinator, stated the correct eye drop administration included pulling the lower eye lid down to make a pocket. LPN-B stated R12 was known to not want her eyes touched and would expect staff attempt to pull the lower eye lid down during the administration of eye drops. On 4/15/25 at 10:32 a.m., the director of nursing (DON) stated during eye drop administration the lower eye lid was expected pulled down to form a pocket in the center of the lower eye lids. The DON stated R12 is known not to like her face touched, however would expect stuff to attempt to pull the lower lid down and explain the process to R12 and expected the care plan to address R12's refusal of her face touched during eye drop administration. The DON confirmed R12's care plan did not include R12's refusal of her face touched during eye drop administration. The DON stated R15's eye drop was expected performed with the lower lid pulled down to create a pocket for the eye drop administration. The DON stated during staff orientation eye drop administration was completed. 42073 R106's facesheet printed on 4/16/25, included diagnoses of glaucoma and ocular pain in right eye. R106's admission MDS assessment dated [DATE], indicated R106 was cognitively intact, had clear speech, could understand and be understood. R106's relied on staff for assistance with most activities of daily living. R106's physician orders included Latanoprost Ophthalmic Solution 0.005 % instill 1 drop in both eyes at bedtime for glaucoma. R106's care plan, last reviewed on 4/1/25, did not include diagnosis of glaucoma. During an observation and interview on 4/14/25 at 7:19 p.m., observed TMA-A place an eye drop into each of R106's eyes. TMA-A placed the tip of the bottle in the inner corner of both eyes and instilled the drops, rather pulling down the lower lid and placing the drop midline in the lower lid pocket. TMA-A stated she was trained to place eye drops in the inner corner. TMA-A was unaware of facility policy regarding instilling eye drops. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25 at 10:25 a.m., the DON described the steps of properly instilling drops in the eye, including having the resident tilt their head back, gently pulling down the lower lid and placing the drop in the pocket of the lower lid. The DON stated proper administration of eye drops was something a nurse or TMA would have learned in training. Facility Eye Drop, Ointment, and Gel Medication Administration policy undated, indicated with a gloved finger, gently pull-down lower eyelid to form pouch, while instructing resident to look up. Place other hand against resident's forehead to steady. Hold inverted medication bottle between the thumb and index finger and press gently to instill prescribed number if drops into pouch near outer corner of eye. Do NOT let the tip of the dropper touch the eye or any other surface. If resident blinks or drop lands on cheek, repeat administration

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on observation, interview and document review, the facility failed to provide shaving for 1 of 1 resident (R45) who was dependent on staff for assistance with grooming and personal hygiene. Findings include: R45's facesheet dated printed 4/16/25, indicated diagnoses included muscle weakness, pain, high blood pressure, and heart failure. R45's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R45 was cognitively intact, used a wheelchair, independent with eating, dependent for bathing and personal hygiene. R45's care plan printed 4/16/25, indicated R45 required staff assist of one for toileting, oral care, bathing, and personal hygiene. During interview and observation on 4/14/25 at 1:53 p.m., R45 had 6 visible chin hairs measuring varying lengths up to 1/2 inch long. R45 had a razor on her bedside table. R45 stated she did not like having chin hairs and wanted staff to shave her chin but thought staff were too busy. During interview and observation on 4/15/25 at 8:39 a.m., R45 was seated in her wheelchair eating breakfast. R45 was fully dressed and groomed for the day, but still had visible chin hairs. R45 stated staff had not offered shaving of her chin hairs while assisting her with grooming that morning. During interview on 4/15/25 at 9:44 a.m., nursing assistant (NA)-E stated she was unaware R45 had long chin hairs. NA-E stated she had heard someone talking about shaving R45 yesterday and they were going to take care of it (shaving) on evening shift. NA-E further stated she did not notice R45 needed to be shaved this morning, did not offer to shave her chin hairs when she assisted her with morning grooming, and she should have shaved her chin if that was what R45 wanted. During interview and observation on 4/15/25 at 1:40 p.m., R45's chin had been shaved. R45 stated she felt so much better and asked if she looked better. R45 was smiling throughout the conversation and showing her chin. During interview on 4/16/25 at 12:31 p.m., registered nurse (RN)-D stated she expected residents to be shave at least weekly and not have visible chin hairs if they did not want chin hairs. RN-D further stated shaving should be part of morning cares. During interview on 4/16/25 at 12:41 p.m., director of nursing (DON) stated she would expect shaving weekly and if a resident wanted to be shaved they should be shaved, especially if chin hair was visible to others. A facility policy on shaving and grooming was requested by not received.

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	245517	A. Building B. Wing	04/16/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on observation, interview and document review, the facility failed to ensure a safe smoking area, extinguishing of cigarettes in designated container, and monitoring of designated smoking area for 2 of 2 residents (R20 and R18) reviewed for smoking. Findings include: R18's facesheet printed 4/16/25, indicated diagnoses of spina bifida, nicotine dependence, and obesity. R18's admission minimum data set (MDS) assessment dated [DATE], indicated intact cognition, use of wheelchair, dependent for bathing, and setup assistance for personal hygiene. R18's care plan printed 4/16/25, indicated resident currently smoked and would smoke safely in designated areas per facility policy. R20's face sheet printed 4/16/25, indicated diagnoses of type two diabetes mellitus and malnutrition. R20's annual MDS dated [DATE], indicated intact cognition, use of wheelchair, substantial assistance with toileting hygiene, and partial assistance with personal hygiene. R20's care plan printed 4/16/25, indicated resident currently smoked and would smoke safely in designated areas per facility policy. During observation on 4/16/25 at 7:14 a.m., R18 and R20 were outside in the designated smoking area at the facility. R18 and R20 were smoking independently and extinguished cigarettes safely in designated disposal container. On and surrounding the designated smoking area were approximately 100 cigarette butts (ends of smoked cigarettes) in the grass, under trees, and on the patio. During interview on 4/16/25 at 8:46 a.m., R18 stated he always put his cigarette butt in the designated container and was not sure where the loose cigarette butts came from. During interview on 4/16/25 at 9:04 a.m., R20 stated there was a previous resident who threw her cigarette butts everywhere and never put them in the designated disposal container. The previous resident had discharged from the facility in December 2024 and had not returned. R20 further stated staff would not know about the mess because they never go back on the smoking patio. During interview on 4/16/25 at 10:00 a.m., housekeeping director stated that she thought maintenance would have been overseeing the smoking area, but no one had done it. Housekeeping director further stated her staff had not been monitoring the smoking area or any outside areas but had been asked to pick up all the cigarette butts in the smoking area few minutes ago. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/16/25 at 8:35 a.m., administrator stated the facility was labeled as a non-smoking facility by signs on the facility door stating non-smoking facility and by notice in the facility policy, but they did let residents smoke. Administrator further stated there was a canister for disposing of cigarettes on the patio and that was where residents were to put their extinguished cigarettes. Administrator was unaware of the cigarettes being thrown on the dry grass, leaves, and under the trees. Administrator agreed cigarettes could potentially start fires if not disposed of properly and could be a safety concern, and confirmed no staff routinely check on the condition or safety of the smoking area. Administrator further stated the maintenance director was new and had not been trained to clean up the smoking area. Facility Oaklawn Rehabilitation Center Smoking Policy dated 8/15/24, indicated the following: Policy Statement: It is the policy of Oaklawn Rehabilitation Center to provide a safe an healthy environment for tenants, staff, and visitors by limiting the use of tobacco and e-cigarette products on it's campus, while also being respectful of the right of each resident to exercise his/her autonomy regarding what they consider to be an important facet of their life. Oaklawn is designated as a non-smoking facility, but due to the lack of safe access to a smoking area off the facility grounds, the back north patio will be designated as a safe smoking location for residents to smoke and dispose of smoking waste. 3. Resident Smoking -Residents are required to use appropriate disposal containers for smoking materials, such as cigarette butts and matches. 5. Enforcement and Compliance -Staff members are responsible for enforcing this policy and addressing any violations. Residents, staff, and visitors found in violation of this policy will be subject to corrective actions, which may include verbal warnings, written notices, or other measures as deemed appropriate by management.

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	245517	A. Building B. Wing	04/16/2025

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 42073 Based on interview and document review, the facility failed to ensure that in the absence of a full-time registered dietician (RD), the culinary services director (CSD)-B was certified to oversee nutrition and food services. This had potential to affect all 45 residents who received meals from the kitchen. Findings include: During the initial kitchen tour on 4/14/25 at 9:40 a.m., CSD-B who had been employed in this role for two years, stated she was not a certified dietary manager (CDM). CSD-B stated she had been enrolled in the course at one time but was not able to complete it. During an interview on 4/15/25 at 11:25 a.m., CSD-B stated the administrator had registered her for the CDM course that morning (4/15/25), and she was now enrolled to take the course. During an interview on 4/15/25 at 2:39 p.m., registered dietician (RD)-C stated she worked part-time at the facility, usually one or two days a week, and communicated frequently with CSD-B via email or phone. RD-C acknowledged CSD-B was new to resident clinical issues, such as monitoring resident weights, but did well on the kitchen side. Facility Culinary Services Director job description, undated, indicated qualifications included: must be a graduate of or currently enrolled in an approved culinary services course that meets the requirements for State and Federal long-term regulations.

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	245517	A. Building B. Wing	04/16/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42073 Based on observation, interview, and document review, the facility failed to ensure 2 of 2 refrigerator/freezers designated for resident food brought into the facility, were monitored to ensure food items were properly stored, labeled, and dated to reduce the risk of contamination and/or foodborne illness. This had the potential to affect any resident who utilized the refrigerator/freezers. In addition, the facility failed to ensure a culinary services cook (CSC)-A wore covering over beard to prevent hair from contaminating food, surfaces and utensils. This had the potential to affect all 45 residents who ate food prepared in the kitchen. Findings include: North Wing Resident Refrigerator: During an observation on 4/14/25 at 2:54 p.m., the resident refrigerator on the North wing was a side-by-side refrigerator/freezer. On the outside of the refrigerator was a sign that indicated: All items placed in this refrigerator must be in a sealed container with name and date. Perishable items are kept for 3 days. A sign on the freezer indicated: All items placed in refrigerator and freezer must be dated and labeled with room number or it will be discarded per department of health guidelines. In the refrigerator were the following items: -- Pizza in a box with a resident name but no date. -- Small Styrofoam container of an orange-colored substance. The container was not covered. No name or date were on the container. -- Small plastic dish of something unidentifiable, with a spoon in it and covered with plastic wrap. No name or date. -- Small cup of dark colored juice with a residents name and dated 4/9 (five days prior). -- Open bottle of Fairlife protein drink; no name or date. -- DoorDash meal in a bag with name but no date. -- Small container of orange substance with cover. No date, no name. -- Soup in a large Ziplock bag, name but no date. In the freezer: -- A light green frozen drink. No name or date. (continued on next page)

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	245517	A. Building B. Wing	04/16/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-- Multiple packages of opened frozen hamburger patties - room number, but no date. South Wing Resident Refrigerator: During an observation on 4/14/25 at 3:15 p.m., on the South wing, the culinary services director (CSD)-B was standing with the refrigerator door open, preparing to mark food with a marker. Prior to doing so, the following items were noted in the refrigerator: -- 3 small Ziploc bags of peeled, overripe bananas; no name or date. CSD-B stated a staff member was going to take them home to make banana bread. -- Store bought container of cantaloupe with room number and no date opened. Seal indicated best by 4/5/25. -- Store bought container of watermelon with room number and no date opened. Seal indicated best by 4/3/25 -- Store bought mixed berries, no name or date. -- Plastic container with food - pasta with sauce - no name or date. CSD-B stated it was likely an employee's food and shouldn't be in the refrigerator. CSD-B stated no one was assigned to monitor the resident refrigerator/freezers - it was everyone's responsibility to monitor them and discard food items not meeting requirements. During subsequent observations on 4/14/25 at 6:42 p.m., (north wing) and at 7:34 p.m., (south wing), the refrigerators and freezers were almost empty after being cleaned out by CSD-B. Hairnet During an observation and interview on 4/14/25 at 11:58 a.m., observed CSC-A who had a full beard, carrying resident meals from the kitchen to the dining room without a beard cover. CSD-B stated she did not know if CSC-A was supposed to cover his beard, and didn't know if the facility had a policy on that. In the meantime, CSD-B gave CSC-A a hairnet to place over his beard. CSC-A also stated he did not know his beard should be covered. Facility Food Brought into Facility policy dated 9/2012, indicated the policy was to address food brought in from the outside with the intent to serve it to all residents. The policy did not include food brought in from the outside for individual residents and stored in resident refrigerator/freezers in common areas. Facility Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy dated 10/2017, indicated hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. Facility Food Preparation and Service policy dated 4/2019, indicated food and nutrition services staff wear hair restraints (hair net, hat, beard restraint) so that hair does not contact food.

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	245517	A. Building B. Wing	04/16/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was donned (put on) and doffed (removed) appropriately for 1 of 1 resident (R206) who had been in transmission-based precautions (TBP) due to testing positive for Covid-19. Findings include: R206's facesheet printed on 4/16/25, indicated R206 was admitted on [DATE], with a diagnosis of Covid-19. R206's physician orders dated 4/11/25, indicated: due to Covid positive status, R206 was to remain on enhanced respiratory precautions and strict isolation during the contagious stage. R206's care plan dated 4/11/25, indicated R206 was on enhanced respiratory precautions related to Covid-19 infection. Staff would follow enhanced respiratory precautions. During an observation on 4/14/25 at 6:25 p.m., observed nursing assistant (NA)-A don PPE to go into R206's room. NA-A donned all appropriate PPE except eye protection. At 6:28 p.m., NA-A exited the room with all PPE having been removed prior to exiting the room. Following this observation, a sign on R206's door indicated R206 was in Enhanced Respiratory Precautions, and gown, facemask or N95, eye protection, and gloves were required when entering the room. NA-A did not don eye protection. There was no eye protection in or on the PPE cart outside R206's room. Further, NA-A had doffed her N95 mask in the room rather than after exiting the room, as directed by the CDC (Centers for Disease Control and Prevention) doffing guidance. NA-A was no longer available for interview. During an interview on 4/14/25 at 7:13 p.m., NA-B stated the required PPE for entering R206's room was gown, N95 mask, face shield and gloves. While standing together looking at R206's PPE cart, NA-B stated, there were no face shields on the cart and went and obtained some, putting them on the top of the cart. During an interview on 4/15/25 at 7:39 a.m., registered nurse (RN)-A, who was also the nurse manager for the unit on which R206 resided, was informed of the observation of an NA entering R206's room without eye protection. RN-A stated they must have run out of eye protection. RN-A stated she would expect staff to know to don all required PPE, including eye protection before entering the room of a resident in TBP for Covid-19. When asked how PPE should be doffed, RN-A looked at CDC doffing instructions and stated PPE should be doffed before exiting the resident room except for the respirator (N95 mask); the respirator (N95 mask) should be removed after leaving the resident room and closing the door. RN-A stated staff should be aware of that - removing the N95 mask after exiting the room as the doffing instructions were posted on the back side of R206's door for them to utilize. RN-A acknowledged with the small size of the print; staff might not notice those instructions. RN-A also acknowledged staff had training on doffing but could have forgotten that step. During an observation and interview on 4/15/25 at 9:46 a.m., observed licensed practical nurse (LPN)-A exit R206's room with all PPE doffed, including N95 mask. LPN-A stated she wasn't aware she should doff the N95 mask after exiting the room, adding, I guess I just forgot that. (continued on next page)

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	245517	A. Building B. Wing	04/16/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/15/25 at 5:12 p.m., observed NA-B exit R206's room with all PPE doffed, including N95 mask. NA-B acknowledged she removed all the PPE including the N95 mask before exiting the room. NA-B stated she wasn't aware she should doff the N95 mask after exiting the room. During an interview on 4/16/25 at 4:49 p.m., the director of nursing (DON) and RN-B, who was also the regional nurse consultant were informed of findings. RN-B stated staff were trained on donning and doffing and would expect they adhere to proper procedure. Facility policy on doffing for TBP was requested and the CDC guidelines were received. The guidelines were undated and titled: HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2 and indicated: to remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. 50764

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	04/16/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on interview and document review, the facility failed to ensure the pneumococcal (PCV20) vaccine was offered or administered as recommended by the Centers for Disease Control (CDC) for 1 of 5 residents (R157) reviewed for immunizations. Findings include: R157's facesheet printed on 4/16/25, indicated and admitted [DATE], and diagnoses of heart failure, muscle weakness, fatigue, and obesity. R157's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and no rejection of care. R157's physician's orders printed on 4/16/25, indicated a past history of pneumonia, unspecified organism. R157's care plan dated 4/7/25, indicated a self care deficit related to weakness and visual impairment and need for assistance with dressing, personal hygiene, and bathing. During record review, there was no documentation in R157's EMR (electronic medical record) for the PCV 20 vaccine or evidence the vaccine had been offered or refused. During interview on 4/16/25 at 2:56 p.m., director of nursing (DON) stated she expected the PCV 20 vaccine to be offered to all residents based on current CDC guidelines and was not sure why this was missed for R157. DON later stated she had now offered the PCV 20 vaccine to R57. DON further stated R157 accepted and would receive the offered vaccine. Facility Pneumococcal Policy updated 2/2024, indicated the following: It is the practice of the Health Care Facility to offer all residents the pneumococcal vaccines to aid in the prevention of pneumococcal/pneumonia infections. The policy further indicated the facility would follow recommendations of the CDC.