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	06/10/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a safe, sanitary and comfortable environment for 1 of 1 residents (R2) whose room was unkept and had resident care items placed on the floor. In addition, the facility failed to perform daily cleaning in the kitchen which had the potential to affect 54/56 residents who received food from the kitchen. Findings include:R2R2's face sheet received on 6/10/26, included diagnoses of diabetes, dementia, and chronic gastritis (inflammation of stomach lining).R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R2 was able to eat independently and required substantial assistance or was dependent on staff for activities of daily living (ADLs). R2 did not walk. R2's physician orders dated 9/24/25, indicated to apply foot to calf wraps (black) at bedtime. Orders dated 3/23/26, indicated Ready Wraps firm and snug around foot, ankle, and calf in the morning. R2's care plan dated 3/11/26, indicated an alteration in mobility related to diagnoses and transferred with a mechanical lift with assist of two staff using a large sling. During an interview and observation on 6/8/26 at 12:06 p.m., R2 was sitting in her recliner. Observed a number of items on the carpeted floor at the foot of her bed: mechanical lift sling, pillow without a pillowcase, blankets, heel boots. Behind the recliner was a piece of wood resembling a slider board, cloth tote bag, blanket. Along with a TV, the top of the built-in credenza was entirely covered with various items: R2's personal items such as stuffed animals, empty vases, candle, figurines, three pair of slipper socks, two denture cups and mail. In addition, facility supplies: two stacks of briefs, two packages of wipes, gait belt, partial package of 4 x 4 dressings, a spray bottle of wound cleanser and chux (absorbent disposable pads). R2 stated staff didn't have time to straighten up her room. During an observation and interview on 6/9/26 at 1:39 p.m., together with nursing assistants NA-A, NA-B, and the director of nursing (DON), entered R2's room to observe items on the floor and the clutter on the credenza. Informed of observation the morning prior with items on the floor. The items that had been on the floor were now heaped on R2's bed. The DON stated staff took items off R2's bed in the evening and put them in her recliner and in the morning, put them back on her bed. With regard to the credenza, the DON stated she expected nurses to put wound supplies away in cupboard and for NAs to put briefs and wipes away. The DON stated extra blankets should be put in her closet. The DON admitted the room lacked storage surfaces for things like heel boots and the sling. During an interview on 6/9/26 at 1:44 p.m., NA-B stated R2 liked lots of blankets because she was usually cold, adding there wasn't enough room for everything and admitted staff could do a better job putting away their supplies. NA-B stated the blankets that had been on the floor the day prior were sent to laundry. During an interview on 6/9/26 at 6:55 p.m., R2 stated she didn't like when staff put things on the floor and didn't like all of the items on the credenza, adding she didn't have the ability to clean up it up herself. R2 stated staff should put their things away.During an interview on 6/10/26 at 7:35 a.m., housekeeper (H)-A stated she cleaned R2's room, and frequently there were items on the floor. H-A acknowledged seeing blankets, pillow, sling and heel boots on the floor, every day. If R2 was in bed, she put those things on her recliner and if she was in her recliner, put things on her bed -- adding (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
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	there weren't enough places to store things. To clean under everything on the credenza, H-A stated she picked up one item at a time, wiped under it and set it back down. H-A stated briefs and wipes were commonly on the credenza. During an interview and observation on 6/10/26 at 9:40 a.m., the credenza had about 50% less items/clutter on it. R2 stated it was much better, I like it. No medical supplies/briefs/wipes were on the credenza. Heel boots, pillow, etc., were on the bed. Facility Personal Belongings policy dated 5/2026, indicated residents were encouraged to personalize their rooms to create a home-like environment. Residents had the right to retain and use personal clothing and possessions as space permitted, provided they did not infringe on the health, safety, or rights of others. At times, a resident's room may need to be cleaned or reorganized.KITCHENDuring initial kitchen tour on 6/8/26 at 6:25 a.m., with cook (C)-A, observed a dusty 8-inch black fan blowing toward food prep area on center island (no food was being prepped at that time). Observed smudges/smears on upper and lower metal cabinet doors, microwave door, and dried liquid drippings down the side of metal cabinet next to the oven. Crumbs on ledge of oven door. Crumbs on the bottom shelf of metal transport cart, crumbs on shelving inside lower metal cabinets. Box fan sitting on top of a yellow rubber receptable on wheels, not turned on, but with grayish material on the blades. Observed the solid surface flooring with non-skid surface; original color appeared to be taupe, but many areas were gray/blackish. Crumbs and debris were on the floor prior to food prep starting for the day. C-A stated dietary staff cleaned the kitchen daily and did a deep clean twice a year. During an interview on 6/9/26 at 10:29 a.m. dietary director (DD)-E and regional culinary director (CD)-F, were informed of concerns with cleanliness in the kitchen. Initially DD-E stated the reason was nursing staff entering the kitchen after hours but admitted that wouldn't account for crumbs inside cupboard shelves, and dirty stainless steel cupboard doors. CD-F stated the responsibility fell to him too; he was supposed to come monthly for a mock survey, but due to his workload, hadn't been able to. DD-E stated there were daily cleaning duties assigned to the cook and dietary aide. Reviewed completed checklists from a folder in her office, titled Closing List for Culinary. One half of the checklist indicated duties for the dietary aide and the other half for the cook. Duties included sweeping, wiping down counters and microwave inside and out, mopping, wiping down all sliding cabinet doors. For June, checklists indicated duties were done on only 6/1/26, 6/3/26, and 6/8/26, and of those, only the aides completed their duties; the cook duties were not initialed as having been completed. DD-E stated if the form had not been completed, she would assume the duties had not been done. Completion of daily Closing List for Culinary: April - completed 15/30 days, May - completed 19/31 days, and June partially completed 3/8 days. During a telephone interview on 6/9/26 at 11:38 a.m., registered dietician (RD)-G was informed of findings related to cleanliness. RD-G stated she was more on the clinical nutrition side and CD-F did the kitchen audits. RD-G had not been aware CD-F had not been able to do the audits due to workload. RD-G was not aware the kitchen had a daily end of shift checklist to complete for the day and evening staff. RD-G stated she would discuss concerns with DD-E and CD-F. During an interview on 6/10/26 at 10:47 a.m., with administrator, DD-E and CD-F, informed of cleanliness findings. The administrator had not been aware and stated they would address it. Facility Cleaning and Disinfection policy dated 9/12, indicated countertops, work surfaces and hard surfaces were to be wiped of excess particle of food, sprayed with a disinfectant solution and re-washed and wiped dry. Facility Sanitization policy dated October 2008, indicated the food service area would be maintained in a clean and sanitary manner. All kitchen areas would be clean. All counters and shelves would be kept clean.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure nutrient and/or calorie substantive snacks were offered after the evening meal and before bedtime, for 2 of 2 residents (R2, R42) when there had been more than a 14-hour lapse between the dinner meal and breakfast the following day. This had the potential to affect 54 of 56 residents who ate meals at the facility. Findings include:R2R2's face sheet received on 6/10/26, included diagnoses of diabetes, dementia, and chronic gastritis. R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R2 was able to eat independently but required substantial assistance or was dependent on staff for activities of daily living (ADLs). R2 did not walk. R2's physician orders dated 1/20/26, included Con/CHO (controlled carbohydrate) 2-gram sodium diet, regular.R2's care plan dated 3/11/26, indicated potential for alteration in nutrition related to diagnoses. During an observation on 6/9/26 at 9:08 a.m., observed R2's breakfast tray delivered to her room. During an interview on 6/9/26 at 5:52 p.m., R2 who preferred to eat meals in her room, stated she went from supper and until breakfast the following day without food and got hungry. R2 stated she would like to eat breakfast earlier in the morning as her breakfast tray arrived late. R42R42's face sheet received on 6/10/26, included diagnoses of diabetes, duodenal ulcer, and chronic kidney disease. R42's quarterly MDS dated [DATE], indicated intact cognition, clear speech, could understand and be understood, and was independent with ADLs.R42's physician orders included consistent carbohydrate diet, regular texture. R42's care plan dated 5/20/26, indicated a potential for alteration in nutrition related to diagnoses. During an interview on 6/8/26 at 10:23 a.m., R42 stated he ate in his room, adding it was pretty typical to eat breakfast around 9:30 a.m. R42 stated he was rarely offered a snack after supper before bed and would like that sometimes. During an observation on 6/9/26 at 9:01 a.m., observed breakfast tray delivered R42's room. During an interview on 6/9/26 at 10:29 a.m., with dietary director (DD)-E and regional culinary director (CD)-F, reviewed a document titled Dietary Service Hours, which indicated the following mealtimes for each unit: BREAKFAST ends at 10:00 a.m.7:30 a.m. dining room opens7:45 a.m. west unit delivery8:15 a.m. east unit delivery8:45 a.m. north unit delivery LUNCH ends at 1:00 p.m.11:30 a.m. dining room opens11:45 a.m. west unit delivery12:15 p.m. east unit delivery12:30 p.m., north unit delivery SUPPER ends at 6:15 p.m.4:45 p.m. dining room opens5:00 p.m. west unit delivery5:30 p.m. east unit delivery6:00 p.m. north unit delivery The dietary service hours indicated 14 hours and 45 minutes between supper one day and breakfast the next morning. DD-E admitted some residents complained about receiving breakfast trays to their room too late in the morning but were told they could come to the dining room for breakfast in order to be served sooner. DD-E stated dietary staff would accommodate resident requests to receive a room tray at a particular time. During an interview on 6/9/26 at 3:28 p.m., registered dietician (RD)-G was unaware of scheduled mealtimes, adding it was her understanding there should be no more than 14 hours between supper and breakfast the following day unless a nutritious snack was provided to residents. Informed the snacks available to residents at bedtimes included unsweetened apple sauce, zero sugar pudding, snack-size bags of pretzels and goldfish crackers, fig bars, cookies, and glazed buns. RD-G acknowledged those snacks wouldn't be considered nutritious.During an interview on 6/10/26 at 10:47 a.m., the administrator, DD-E and CD-F were informed of the concern of more than 14 hours between the supper meal and breakfast the next day without a nourishing snack. The Dietary Service Hours sign was given to the administrator for review. Informed there should be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime. The dietary manager acknowledged the snacks available to residents at bedtime would not be considered nourishing. The administrator was unaware and stated (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mealtimes would be addressed. Facility Mealtime policy dated 9/2012, indicated it was the policy to serve meals to meet the standards of the surveying agencies specifying no more than 14 hours between the evening meal one day and the breakfast meal of the next day.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure appropriate follow-up of urine culture and sensitivity results and failed to ensure antibiotic therapy was reviewed for effectiveness for 1 of 1 resident (R32) reviewed for antibiotic use. In addition, the facility failed to ensure a nutritious snack was offered for the management of low blood sugar and failed to inform the dietician of concerns with blood sugar levels for 1 of 1 resident (R50) reviewed for food.Findings include: Antibiotic Use R32's significant change in status [NAME] Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, utilized a wheelchair, required supervision or touching assistance with toileting hygiene and personal hygiene, diagnoses included bladder cancer, hydronephrosis (urine doesn't fully empty from the body), and hematuria (blood in urine). R32's care plan dated 5/5/26, indicated alteration in elimination d/t (due to) weakness and assist with 2 staff and transfers, bladder cancer and prostate cancer assist of 2 with toileting, monitor urine for increased blood or pain with urination, will continue to have follow up appt with urology as scheduled, provide assistance with peri-cares AM (morning), HS (bedtime) and PRN (as needed), monitor foley catheter output, change foley catheter per policy, foley catheter care per policy. R32's urinalysis microbiology results dated 6/1/26, indicated greater than 100,000 colony forming units per milliliter (CFU/mL) of gram-negative rods with identification and sensitivity pending (lab has confirmed the bacteria's species in the urine and is still running tests to see which antibiotics will work against it). R32's medication administration record (MAR) dated 6/1/26-6/30/26, indicated: Start date 6/1/26, UA/UC (urinalysis/urine culture) one time only for possible UTI (urinary tract infection) Start date 6/4/26, Ciprofloxacin (antibiotic) give 500 mg (milligrams) by mouth two times a day related to hematuria, for 5 Days, and discontinued 6/8/26. Start date 6/8/26, Sulfamethoxazole-Trimethoprim (antibiotic) give 1 tablet by mouth two times a day for UTI (urinary tract infection) for 7 days R32's urine culture and sensitivity report dated 6/3/26, identified the organism as resistant (R) to ciprofloxacin. On 6/8/26 at 1:46 p.m., licensed practical nurse (LPN)-B stated urine culture results were typically reviewed by the facility nursing staff and the provider would be expected to be notified if an organism was resistant to the prescribed antibiotic. LPN-B stated nursing staff were expected to address culture results and communicate concerns to the provider. On 6/8/26 at 1:56 p.m., the director of nursing (DON) reviewed R32's urine culture results dated 6/3/26, and confirmed the organism was resistant to ciprofloxacin. The DON confirmed R32 was currently prescribed ciprofloxacin. The DON stated nursing staff were expected to review culture and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sensitivity reports, verify the prescribed antibiotic was susceptible to the identified organism, and notify the provider when resistance was identified. The DON stated they would have expected the provider to be notified regarding the resistant organism prior to 6/8/26. The DON further stated nursing staff was expected to place the paper copy of resident's culture in her office mailbox or under her office door as the she was the infection prevention nurse to include on her surveillance of infections. On 6/8/26 at 2:05 p.m., registered nurse (RN)-E, hospice nurse, stated ciprofloxacin had been ordered for R32 on 6/3/26, to provide coverage until culture results were available and stated facility nursing staff would be expected to notify hospice or the provider when culture results demonstrated resistance. On 6/8/26 at 2:12 p.m., LPN-C stated facility staff were expected to contact the provider when culture results indicated the prescribed antibiotic did not cover the identified organism. LPN-C stated she recalled receiving the culture results, signed off that they were reviewed, and provided the results to the hospice nurse for follow-up but did not document provider notification or the specific culture findings. On 6/8/26 at 2:44 p.m., LPN-B stated staff would generally assume culture results had been addressed if the paper copy was signed, and stated there was no process ensuring follow-up occurred after review of the culture results. On 6/8/26 at 3:28 p.m., RN-F, hospice nurse, stated R32's urine culture results were forwarded to the provider but acknowledged there was a breakdown in communication regarding review of the sensitivity report between the provider, hospice nurse and the facility. RN-F stated when the order was received for R32's cipro antibiotic hospice had not clarified if the provider had reviewed the culture results before continuing the antibiotic. On 6/8/26 at 3:43 p.m., the DON stated culture and sensitivity results should be reviewed to ensure the prescribed antibiotic is effective against the identified organism and acknowledged R32 was not included on the facility's infection tracking log. On 6/9/26 at 3:22 p.m., R32 stated he felt fine and denied urinary symptoms. Facility Antibiotic Stewardship Program Policy dated 11/24, indicated The Infection Preventionist, (IP), or designee, will review all antibiotic orders to determine if treatment is appropriate. Treatment is not appropriate if: The organism is not susceptible to the antibiotic chosen. The organism is susceptible to a narrower spectrum antibiotic. Therapy was ordered for prolonged surgical prophylaxis. Therapy was started awaiting culture, but no organism was isolated after 72 hours (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The provider will be notified of the review findings and recommendations and a response will be documented in the resident's medical record. The Infection Preventionist, along with the Consultant Pharmacist, will monitor antibiotic use by utilizing a facility approved infection/antibiotic surveillance tracking form and thru monthly medication reviews. The information gathered will include: Resident name Unit and room number Date symptoms appeared name of antibiotic Start date of antibiotic Pathogen identified Site of infection Date of culture Stop date Total days of therapy Outcome Adverse events, if applicable. Management Of Low Blood Sugar R50's face sheet dated 4/18/26, indicated diagnoses of infection of skin tissue, type two diabetes mellitus with foot ulcer, moderate protein-calorie malnutrition, abnormal weight loss, long term use of insulin. R50's admission Minimum Data Set (MDS) assessment dated [DATE], indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, independent with eating, partial assistance with dressing. R50's care plan printed 6/10/26, indicated potential for alteration in blood sugar related to diagnosis of diabetes. Resident will be free from hyper/hypo glycemic episodes. Monitor for signs of hyper/hypoglycemia, diet as ordered. R50's physician's orders dated 6/4/26, indicated orders for continuous blood glucose sensor, metformin, Mounjaro, Jardiance, and Lantus (diabetic medications), consistent carbohydrate diet, follow standard house orders for blood sugars, monitor for signs of hyper/hypoglycemia, blood sugars before meals and at bedtime. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/9/26 at 3:03 P.M., R50 stated he was happy with the care he received at the facility, but worried about his blood sugars. R50 stated supper was served at 4:45 p.m., and that was too early for him to eat to sustain his blood sugar through the night. R50 further stated that sometime he didn't get breakfast until 9:00 a.m., and his blood sugar would be lower throughout the night and in the morning. R50 stated he was not offered a substantial evening snack to help keep his blood sugar up through the night, but he had his daughter bring some snacks in for him to have in his room. R50 stated he did not like the feeling of low blood sugar and it worried him when it happened. R50 stated a blood sugar reading in the 90's or lower made him worry he was going to drop even more throughout the night and before breakfast without a substantial snack. Review of R50's blood sugar readings from 5/31/26 through 6/9/26, indicated the following readings he was not comfortable with: 5/31/26 at 9:10 a.m.: 87 6/4/26 at 10:10 p.m.: 88 6/5/26 at 8:02 a.m.: 86 6/8/26 at 7:06 a.m.: 65 6/9/26 at 7:33 p.m.: 86 During interview on 6/8/26 at 3:20 p.m., registered nurse (RN)-B stated there was an evening snack cart but there was nothing designated specifically for diabetic residents and nothing to indicate who should be offered a snack in the evening. RN-B further stated there were mostly carbohydrate snacks on the cart, no order for a substantial evening snack for diabetic residents, but that R50 could ask for something if he wanted a snack. On 6/8/26, the snack cart included unsweetened applesauce, zero sugar pudding, pretzels, goldfish crackers, fig bars, cookies, and honey buns. During interview on 6/9/26 at 3:03 p.m., RN-G stated there were no specific orders for a substantial evening snack for diabetic residents, but a snack cart was put out each evening. RN-G stated nothing was offered specifically to diabetic residents to ensure their blood sugar did not drop overnight or prior to breakfast. During interview on 6/9/26 at 3:23 p.m., director of nursing (DON) stated she was aware R50's blood sugar had been dropping consistently overnight and the provider had been notified to make medication changes, but had not considered providing an evening snack and had not contacted the dietician. DON stated providing diabetic snacks was not something they did, they just had a snack cart available for all residents. DON stated there was nothing labeled on the snack cart for diabetic residents to ensure they were offered a snack. DON stated she would have to add that order for diabetic residents to help maintain blood sugar overnight. During interview on 6/9/26 at 3:30 p.m., registered dietician (RD) stated she was newer to the facility and was not sure what was offered on the snack cart. RD stated she would expect snacks offered to diabetic residents after supper and they should include a carbohydrate and protein source. RD stated she would expect to be notified if a resident was having difficulty with blood sugar management so (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she could provide an order for a diabetic snack at night. RD stated she had not been made aware of any concerns with R50's blood sugar levels. Facility Snack Carts policy dated 9/2012, indicated facility policy to provide a nourishing snack daily. The hospitality staff will set up the cart and each cart will include these items: snacks, bars, cookies, fruit, crackers, sandwiches, beverages. These carts will be brought around to the resident's rooms by the nursing assistants.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to assess and implement interventions to maintain and/or prevent loss of range of motion (ROM) for 1 of 1 resident (R21) reviewed for ROM.Findings include: R21's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, no rejection of care, utilized a wheelchair, independent with eating, setup or clean-up assistance with oral hygiene, dependent with toileting hygiene, sit to lying, chair to bed transfer, toilet transfer, lower body dressing, substantial/maximal assistance with shower/bathe self, roll left and right, upper body dressing, and partial moderate assistance with personal hygiene; limitation range of motion on both sides of lower extremity and no impairment on upper extremity; diagnoses included non-Alzheimer's dementia, depression, Parkinsonism and not receiving a restorative nursing program.R21's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition, no rejection of care, utilized a wheelchair, with eating, setup or clean-up assistance with eating, dependent with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, sit to lying, chair to bed transfer, toilet transfer; limitation range of motion on both sides of lower extremity and no impairment on upper extremity; diagnoses included non-Alzheimer's dementia, depression, Parkinsonism and not receiving a restorative nursing program.R21's care plan dated [DATE], indicated Parkinsonism, age-related physical debility, pain, osteoarthritis, history of falling, and weakness and interventions included PT (physical therapy) per MD (medical doctor)order, follow PT instructions, A (assist) x2 using mechanical lift for transfers, assist with movement in bed and in/out of bed, OT (occupational therapy) per MD order, follow OT instructions, assist with bathing with assist of 1 staff, assist with dressing with assist of 1 staff, assist with personal hygiene with assist of 1 staff.R21's document review failed to indicate documentation of interventions to maintain or prevent loss of ROM or strength of lower extremities.On [DATE] at 7:13 a.m., R21 stated, I've asked about a stationary bike and weights, but get brushed off. I would like to keep my flexibility. R21 stated they do not walk, received no exercise to their joints, and expressed concern about losing her ability to move her joints freely.On [DATE] at 2:24 p.m., R21 was observed lying in bed and stated the facility did not provide exercises for the upper or lower body to maintain strength and stated they would participate if exercises were offered.On [DATE] at 2:28 p.m., nursing assistant (NA)-A, NA-B, NA-C stated exercise and restorative interventions would be documented in the electronic medical record (EMR) if in place. The nursing assistants reviewed the EMR and therapy communication book and confirmed there were no orders, tasks, or documentation indicating exercises, range of motion interventions, or restorative services for R21. NA-A, NA-B, NA-C further confirmed R21 required a mechanical lift and assistance of two staff for transfers.On [DATE] at 2:31 p.m., registered nurse (RN)-A, known as nurse manager, and licensed practical nurse (LPN)-A, known as a care coordinator, stated R21 was not on restorative program. RN-A stated therapy will pick residents up for for services if there is a specific need but services may be discontinued once a resident plateaus and confirmed there was nothing specific in place for R21 to maintain their strength.On [DATE] at 3:50 p.m., LPN-A stated if a resident had a decline in ADLs (activities of daily living) the decline would typically be discussed during routine Medicare meetings and therapy referrals would be considered if a decline was identified. When asked what interventions were currently being implemented to prevent decline, LPN-A stated she would need to look into it and noted that long-term care residents generally decline over time. RN-A stated the facility practice was for therapy to evaluate residents once a decline was observed.On [DATE] at 11:13 a.m., RN-B stated R21 required a wheelchair, assistance of two staff, and a mechanical lift for transfers, and further stated R21 was not receiving therapy services, had no range of motion program, and had no interventions in place to maintain strength.On [DATE] at 11:14 a.m., RN-C stated therapy (continued on next page)

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	06/10/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would write any orders related to exercises or ROM programs if staff were expected to complete ROM with a resident and confirmed there were no ROM interventions for R21.On [DATE] at 11:15 a.m., NA-B stated R21 currently had nothing in place to maintain their strength such as ROM or exercises.On [DATE] at 11:16 a.m., RN-A and LPN-A stated they were unsure whether an order was required for ROM interventions and stated residents were typically referred to therapy after a decline was identified and confirmed there was currently nothing in place to prevent decline for R21.On [DATE] at 11:24 a.m., R21 was observed in bed and stated she was not offered exercises but would participate if they were available. R21 stated exercises would be nice to keep her strength up. R21 stated there were weights under my clothes across the room and stated she could not reach them. Two hand weights were observed across the room from R21's bed and found underneath clothing. R21 stated she would use the weights if they were placed within reach. R21's fingers on the right hand were curled inward toward the palm, the resident could open and close both hands, wiggle toes, but was unable to raise either leg from the bed.On [DATE] at 11:32 a.m., RN-A confirmed R21 had weights and exercise bands in their room, but was unsure where they had originated and if R21 was supposed to use them.On [DATE] at 11:34 a.m., the director of nursing (DON) stated residents were expected and should be encouraged to do as much as possible independently. DON stated therapy typically provided ROM exercises if a resident was expected to complete exercises and staff should report changes in condition to therapy. The DON further stated staff were expected to address declines and not simply capture them through MDS documentation. The DON stated exercises were important to keep the strength a resident has and maintain the strength. The DON stated if R21 had ROM limitations, would expect nursing to alert therapy to ensure interventions were in place for R21.On [DATE] at 1:38 p.m., the director of rehabilitation (DOR) stated they reviewed R21's information and stated therapy would typically provide recommendations for upper- or lower-extremity exercises as needed. DOR stated it was beneficial for residents to have a restorative nursing program to maintain current abilities and indicated that interventions to help prevent decline would have been warranted for R21.On [DATE] at 9:03 a.m., OT (occupational therapist)-A [NAME] stated the facility had a transition of therapy companies and was unable to find documentation on whether R21 previously had exercise orders; however, OT-A stated they would have expected interventions to be in place due to R21's decreased lower-extremity function and limited range of motion. OT-A stated R21 had not walked for a long time and would expect PT (physical therapy) recommendations for lower-extremity exercises and reported PT had been asked yesterday to reassess the resident for possible restorative programming.On [DATE] at 10:00 a.m., RN-D, known as regional nurse consultant, stated the facility could not locate a previous physical therapy discharge recommendation, and further stated with the transition to a new PT provider the documentation was not readily available. RN-D stated R21 was evaluated by PT yesterday ([DATE]). The Facility Activities of Daily Living (ADLs)/Maintain Abilities Policy dated [DATE], indicated1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living.3. The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems.4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.