DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7OX0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00679

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245581**
2.STATE VENDOR OR MEDICAID NO.
(L2) **719475700**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIR OAKS LODGE**
(L4) **201 SHADY LANE DRIVE**
(L5) **WADENA, MN** (L6) **56482**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2004**

6. DATE OF SURVEY **02/19/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 03/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/26/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5581

On February 12, 2014 this Department notified the facility of the imposed rememdy we recommended to the CMS Region V Office for imposition:

Mandatory Denial of Payment for new Medicare and Medicaid Admissions (DOPNA), effective March 5, 2014. If DOPNA goes into effect, the facility would be subject to a two year loss of NATCEP beginning March, 2014.

On February 19, 2014 the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on February 14, 2014, the Minnesota Department of Public Safety completed a PCR and it was determined all deficiencies had been correction, effecitive February 14, 2014. As a result of our findings, we are recommending the following to the CMS RO for imposition:

Mandatory DOPNA, effective March 5, 2014, be rescinded.

Since DOPNA never went into effect, the facility would not be subject to the two year loss of NATCEP beginning March 5, 2014.

Refer to the CMS2567b (for both health and life safety code).

Effective February 14, 2014, the facility is certified for 75 skilled nursing facility beds,

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5581

March 8, 2014

Mr. Richard Blanchard, Administrator
Fair Oaks Lodge
201 Shady Lane Drive
Wadena, Minnesota 56482

Dear Mr. Blanchard:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 14, 2014 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.
Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8163

February 12, 2014

Mr. Richard Blanchard, Administrator
Fair Oaks Lodge
201 Shady Lane Drive
Wadena, Minnesota 56482

RE: Project Number S5581023

Dear Mr. Blanchard:

On December 23, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 5, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the December 5, 2013 standard survey has not yet been verified. The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 5, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 5, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 5, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Fair Oaks Lodge is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 5, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new

admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 5, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245581	A. Building B. Wing	2/19/2014

Name of Facility	Street Address, City, State, Zip Code
FAIR OAKS LODGE	201 SHADY LANE DRIVE WADENA, MN 56482

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/14/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/14/2014**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **01/14/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/14/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/14/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **01/14/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GA	03/10/2014	32600	02/19/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/5/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245581	A. Building 01 - DINING ADDITION 01 B. Wing	2/14/2014

Name of Facility	Street Address, City, State, Zip Code
FAIR OAKS LODGE	201 SHADY LANE DRIVE WADENA, MN 56482

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 01/12/2014	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 01/12/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/PS	Date: 03/10/2014	Signature of Surveyor: 03006	Date: 02/14/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/3/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Protecting, Maintaining and Improving the Health of Minnesotans

March 4, 2014

Mr. Richard Blanchard, Administrator
Fair Oaks Lodge
201 Shady Lane Drive
Wadena, Minnesota 56482

RE: Project Number S5581023

Dear Mr. Blanchard:

On December 12, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 5, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter of February 12, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 5, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on December 5, 2013, , and lack of verification of substantial compliance with the health and Life Safety Code (LSC) deficiencies at the time of our February 12, 2014 notice. The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On February 19, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 14, 2014 the Minnesota Department of Public Safety complete a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 5, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 14, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 5, 2013, as of January 14, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of February 12, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 5, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 5, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 5, 2014, is to be rescinded.

In our letter of February 12, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 5, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 14, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Enclosure

cc: Licensing and Certification File 5581r14_2_70dayAllCorr.rtf

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 7OX0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00679

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245581**
2.STATE VENDOR OR MEDICAID NO.
(L2) **719475700**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIR OAKS LODGE**
(L4) **201 SHADY LANE DRIVE**
(L5) **WADENA, MN** (L6) **56482**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2004**

6. DATE OF SURVEY **12/05/2013** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 02/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5581

On December 5, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7319

December 23, 2013

Mr. Richard Blanchard, Administrator
Fair Oaks Lodge
201 Shady Lane Drive
Wadena, Minnesota 56482

RE: Project Number S5581023

Dear Mr. Blanchard:

On December 5, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be

contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Telephone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 14, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 14, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 5, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 5, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS LODGE	201 SHADY LANE DRIVE WADENA, MN 56482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the care plan for dialysis site access care and emergency procedures for 1 of 1 resident (R74) reviewed for dialysis services. Findings include: R74's current care plan dated 11/14/13, identified R74 received dialysis therapy routinely every Monday, Wednesday and Friday. The care plan listed various interventions which included to monitor, document and report to the physician any signs or symptoms of bleeding, hemorrhage, bacteremia, septic shock. The care plan also	F 282		

2/11/14 Attachment A

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

Richard M Stensland — Administrator — 12/20/14

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.

01/06/14

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F 282	Continued From page 1 directed staff to monitor, document and report any signs or symptoms of infection to the access site; redness, swelling, warmth or drainage. R74's current December 2013 physician orders, identified a left arm shunt (access site for dialysis therapy) and directed removal of dressing two hours after returning from dialysis treatments. Review of R74's treatment record for November 2013 and December 2013 revealed staff had documented removal of R74's dressing on November 26, 27, 28, 29, 30; and December 1, and 2 (seven days in a row). On 12/413, at 1:03 p.m. a nursing assistant (NA)-A confirmed R74 had a dialysis access in the left arm and indicated he routinely left the facility for dialysis treatments. On 12/4/13, at 1:13 p.m., licensed practical nurse (LPN)-B described R74's dialysis access as a catheter with a three port line in R74's chest. LPN-B stated she did not evaluate or monitor the dialysis access site. LPN-B stated she was not aware of any emergency procedures to follow for care of R74's dialysis access, nor was she aware of special precautions to follow for R74. LPN-B confirmed she did not perform any routine monitoring. On 12/4/13, at 3:07 p.m. registered nurse (RN)-B stated she was not aware what type of access R74 had, nor was she aware of emergency procedures for the dialysis access. RN-B stated she would need to see if there were any emergency procedures provided by the dialysis unit, and further stated the routine practice was to call the facility on call physician if needed. RN-B	F 282	• F282 **Resident #74 has been discharged from facility.** **Resident has had care plans integrated to reflect dialysis services.** **All residents receiving dialysis services have the potential to be affected by this practice.** **NM's have received education on ensuring that a comprehensive plan of care completed on residents receiving dialysis.** **DON will audit weekly to assure that all patients receiving dialysis for care plan accuracy.** **Audits will be reviewed to check for timelines and trends of completing POC and will be reviewed at QAA for three months.** **Deficient practices to be corrected by January 14, 2014.**	

STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 2 confirmed no routine monitoring had been performed. RN-B confirmed R74 received dialysis therapy three days a week, Monday, Wednesday and Friday, and further confirmed the treatment record had been incorrectly documented for removal of the dialysis dressing seven days in a row. On 12/5/13, at 2:26 p.m. the director of nursing (DON) confirmed R74's current care plan. She stated R74 had a internal shunt in his left arm for dialysis and indicated the reports from staff that R74 had an external catheter for dialysis were incorrect. The DON stated she would expect the staff to follow the care plan and confirmed nursing duties for dialysis included to check the dialysis access was functional by checking for a thrill or bruit, and to remove the dressings following the doctor's orders. A requested dialysis policy was not provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services for care and monitoring the	F 309		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 dialysis access site for 1 of 1 resident (R74) who received dialysis services. Findings include: During observation on 12/2/13, at 5:50 p.m. R74 was fully dressed, seated alone at a table in the dining room. Both arms were covered with coat sleeves with his body leaned forward and head resting on the table with eyes closed. No dressing was visible nor was discoloration observed on the sleeves of his clothes. The current physicians orders (dated as printed on 12/4/13) identified R74's diagnoses included end stage renal disease, mild intellectual disability, and bipolar disorder. The admission Minimum Data Set (MDS) dated 9/13/13, identified R74 received routine dialysis therapy, required assistance with decision making, and required assistance with all activities of daily living (ADL). R74's current care plan dated 11/14/13, identified R74 received dialysis therapy routinely every Monday, Wednesday and Friday. The care plan directed staff not to draw blood or take blood pressure in the arm with the graft, and to monitor, document and report to the physician any signs or symptoms of bleeding, hemorrhage, bacteremia, septic shock. The care plan also directed staff to monitor, document and report any signs or symptoms of infection to the access site; redness, swelling, warmth or drainage. R74's current December 2013 physician orders, identified a left arm shunt (access site for dialysis therapy) and directed removal of dressing two hours after returning from dialysis treatments.	F 309	• F309 **Resident #74 has been discharged from facility.** **Resident has had his POC integrated to include dialysis services emergency protocol and monitoring of his access site.** **All residents receiving dialysis services have the potential to be affected by this practice.** **NM's and licensed nurses have been educated care of the dialysis patient to reflect dialysis emergency protocols and monitoring dialysis site.** **NM's and licensed nurses have reviewed all residents receiving dialysis services to ensure resident emergency services and site monitoring needs are being met.** **DON will audit facility system to assure nurses are aware of emergency services and site monitoring protocols.** **Audits will be reviewed at QAA for three months to ensure coordination of dialysis services.** **Deficient practice to be corrected by January 14, 2014.**	

STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 4 R74's treatment record identified staff documentation of R74's dressing removal on November 26, 27, 28, 29, 30; and December 1, and 2 (seven days in a row). On 12/413, at 1:03 p.m. a nursing assistant (NA)-A confirmed R74 had a dialysis access in the left arm and indicated he routinely left the facility for dialysis treatments. On 12/4/13, at 1:13 p.m. the licensed practical nurse (LPN)-B described R74's dialysis access as a catheter with a three port line in R74's chest. LPN-B stated she did not evaluate or monitor the dialysis access site. LPN-B stated she was not aware of any emergency procedures to follow for care of R74's dialysis access, nor was she aware of special precautions to follow for R74. LPN-B confirmed she did not perform any routine monitoring. On 12/4/13, at 3:07 p.m. the registered nurse (RN)-B stated she was not aware what type of access R74 had, nor was she aware of emergency procedures for the dialysis access. RN-B stated she would need to see if there were any emergency procedures provided by the dialysis unit, and further stated the routine practice was to call the facility on call physician if needed. RN-B confirmed no routine monitoring had been performed. RN-B confirmed R74 received dialysis therapy three days a week, Monday, Wednesday and Friday, and further confirmed the treatment record had been incorrectly documented for removal of the dialysis dressing seven days in a row. On 12/5/13, at 2:26 p.m. the director of nursing	F 309		

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F 309	Continued From page 5 (DON) confirmed R74's current care plan. She stated R74 had a internal shunt in his left arm for dialysis and indicated the reports from staff that R74 had an external catheter for dialysis were incorrect. The DON stated she would expect the staff to follow the care plan and confirmed nursing duties for dialysis included to check the dialysis access was functional by checking for a thrill or bruit, and to remove the dressings following the doctor's orders.	F 309		
F 322 SS=D	A requested dialysis policy was not provided. 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --	F 322		
	(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.			

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F 322	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer medications via gastrostomy tube (G-tube) individually with appropriate water flushes for 1 of 1 resident (R90) who received G-tube medications. Findings include: The admission record dated 12/29/12, identified R90's diagnoses to include status post stroke, dysphagia (difficulty swallowing) and G-tube placement. On 12/4/13, at 9:13 a.m. licensed practical nurse (LPN)-A prepared Baclofen 10 milligram (mg) tablet (for involuntary muscle spasms) and aspirin 81 mg tablet. The tablets were crushed and dissolved in a small amount of water in a medication cup. Zoloft 50 mg (anti-depressant) liquid was measured into a separate medication cup. Reglan 10 mg (for gastroesophageal reflux) liquid was drawn into a syringe and then added to the medication cup with Zoloft. The liquid medications and the dissolved tablets were mixed with approximately 100 cubic centimeters (cc) of water in a drinking glass to create a cocktail of all the medications. LPN-A entered R90's room and applied gloves. She exposed R90's G-tube and connected an open ended syringe to the G-tube and poured approximately 120 cc of water into the open end of the syringe. LPN-A then poured the medication cocktail into the syringe, allowed the medications to instill via gravity and flushed with approximately 30 cc of water. On 12/4/13, at 12:26 p.m. LPN-A stated she	F 322	F322 **Resident #90 has been observed and suffered no ill effects from this practice.** **All residents who receive medication administration through a feeding tube can be affected by this practice.** **Nurse has been re-educated on policy for medication administration through a feeding tube.** **Licensed nurses at facility will be educated on policy and safe practice guidelines.** **NM will complete random audits x2 weekly to insure that medication administration through feeding tube is being performed according to policy.** **Audits will be reviewed at QAA for three months to ensure adherence to policy is being followed.** **Deficient practice to be corrected by January 14, 2014.**	

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F 322	Continued From page 7 routinely administered G-tube medications by mixing them together and administering them at one time. On 12/4/13, at 12:28 p.m. registered nurse (RN)-A stated G-tube medications should be administered individually with a flush of water before, after, and between medications. RN-A also stated a computer based training module had been developed for administration of medications via G-tube. The Gastrostomy Tube-Administration of Medications policy reviewed April 2009, directed, "Medications are not to be mixed and are to be given one at a time, followed by water as needed."	F 322		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		

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F 431	Continued From page 8 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow currently accepted principles for disposal of controlled substances for 4 of 4 residents (R62, R34, R6, R24) who were prescribed Fentanyl patches. Findings include: MED STORAGE REVIEW: During medication storage review on 12/4/13, at 10:50 a.m. on 2nd floor the trained medication aide (TMA)-A and licensed practical nurse (LPN)-B present for the review. Both staff verified Fentanyl patches prescribed to residents were routinely disposed of by staff and by routinely folding the used patch and placing it into a sharps container. LPN-B verified there was one resident (R62) on the 2nd floor, who was currently prescribed a Fentanyl patch. LPN-B verified the patch was changed every three days in the evening.	F 431	• F431 **Due to insufficient practice no residents have been harmed by the practice of disposing of used fentanyl patches in the sharps container.** **Licensed nurses and TMA's have been educated on facility's policy of destruction of fentanyl patches as follows; After removing the fentanyl patch, immediately dispose of the used patch safely by folding the adhesive sides of the patch together (until it adheres to itself) and flushing it down the toilet in the presence of a witness.** **Documentation of destruction by both witnesses is required.** **DON/designee will audit removal of Fentanyl patches once weekly to insure fentanyl patch destruction policy is being followed. Audits will be reviewed at QAA for three months to ensure compliance with policy.** **Deficient practice to be corrected by January 14, 2014.**	

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F 431	Continued From page 9 - At 11:15 a.m. on the 1st floor the medication storage review was conducted with LPN-A. LPN-A verified Fentanyl patches prescribed to residents were routinely disposed of by a facility staff person by folding the used patch and placing it in a sharps container. LPN-A confirmed there were three residents (R34, R6, R24) on the 2nd floor that received Fentanyl patches in the evening. On 12/4/13, at 1:20 p.m. registered nurse (RN)-C stated disposal of Fentanyl patches were to be witnessed by two staff. RN-C stated these staff should be the person administering the patch and one other staff. RN-C stated the patch should be folded and placed in a sharps container, and documented on the electronic record. RN-C stated the sharps containers were stored in the utility/equipment room until picked up by the waste vendor. On 12/4/13, at 1:50 p.m. RN-C provided a copy of the facility policy titled, "Policy for disposal of used Fentanyl patches" dated 4/1/2012. The policy indicated the facility would properly handle and dispose of used Fentanyl patches in accordance with manufacturer and FDA recommendations. The policy indicated Fentanyl was on the FDA list of medications recommended for disposal by flushing. The policy directed staff after removing the Fentanyl patch, immediately dispose of the used patch safely by folding the adhesive sides of the patch together and flush it down the toilet. The policy did not direct staff to have two staff present while disposing. On 12/4/13, at 2:00 p.m. LPN-A showed the surveyor the electronic medical record of R34's last Fentanyl patch administration and stated the	F 431		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 10 electronic record did not have a place for two staff to sign. LPN-A verified the 12/2/13, documented statement regarding the Fentanyl patch administration lacked two staff witnessing. On 12/4/13, at 3:15 LPN-C, who worked on the 1st and 2nd floor on the evening shift stated she had administered Fentanyl patches to all four of the residents listed above. LPN-C stated she destroyed Fentanyl patches by flushing them down the toilet. LPN-C stated she was unaware two staff should be witnessing destruction. On 12/5/13, at 9:25 a.m. the director of nursing (DON) verified the current practice for destruction of Fentanyl patches was for the staff to flush down the toilet and to destroy/dispense the patch with a witness.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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F 441	Continued From page 11 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an ongoing surveillance program for residents and employees which included trending and tracking of infections, analysis of specific organisms, antibiotic use to prevent the spread of infection. This practice had the potential to affect all 68 residents who resided in the facility. Findings include: On 12/5/13, at 9:12 a.m. the facility infection control program was reviewed with the registered nurse lower level unit manager (RN)-A. RN-A stated each nurse manager was responsible to track the infections on their unit and the health information manager (HIM) was responsible to	F 441	• F441 **No residents have been noted to be affected by facilities infection control program lacking surveillance.** **Facility infection control system has been reviewed and the ADON will now be the IC nurse in the facility.** **ADON will receive education on tracking and analysis on data collected to prevent the spread of infection. This will include resident and employee illness.** **DON will audit weekly to assure proper documentation of analysis and collection of data is taking place.** **Audits will be reviewed at QAA for three months to ensure adherence to infection control surveillance is being followed.** **Deficient practice to be corrected by January 14, 2014.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS LODGE	201 SHADY LANE DRIVE WADENA, MN 56482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12	F 441		

track employee infections. RN-A indicated the floor nurses documented new infections with an antibiotic prescription on the Monthly Infection Control Log. The residents' name, admit date, room number, unit, type of infection, antibiotic type and start date, and classification were entered into the log. RN-A stated she reviewed the log each weekday and marked the room of the affected residents on a floor plan if any increase in infections were noted. RN-A also stated all infections were reviewed at the monthly quality assurance and assessment (QAA) meeting.

On 12/5/13, at 10:02 a.m. the employee infection control program was reviewed with HIM. She indicated she maintained a log of employee infections which included employee name, onset date, symptoms, antibiotics, length of antibiotics and temperature. HIM stated she was behind in updating the Employee Infection Control Log by approximately one month. HIM also stated she did not meet with the RNs on a regular basis to review infections, only if an increase in "call in's" was noted.

On 12/5/13, at 10:19 a.m. the director of nursing (DON) stated an interdisciplinary team met daily for a brief focus meeting where new infections are discussed. She also stated she reviewed the individual floor infection control logs at the monthly QAA meeting for the previous month, but at no time was a current facility wide review documented.

Review of the infection control program revealed the system lacked an overall facility approach. Surveillance of infections for residents on the lower level was monitored by RN-A, residents on

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F 441	Continued From page 13 the main floor was monitored by RN-B and employee infections were monitored by HIM. A comprehensive analysis of infections for the entire facility was lacking. Review of the resident Monthly Infection Control Logs for October, November, and December 2013, showed only infections with antibiotic prescriptions were tracked and identification of the infectious organism was lacking. The tracking system lacked trending of infections without antibiotics. Review of the Employee Infection Control Logs revealed a log had not been initiated for December 2013. Review of the November 2013 log revealed tracking had not been initiated since 11/11/13, and comparison surveillance between resident and employee illnesses was not established. On 12/5/13, at 12:53 p.m. RN-A stated she was only tracking infections with antibiotic prescriptions on the monthly log. She confirmed the facility had not established a system to track infections which did not require antibiotics. On 12/5/13, at 1:04 p.m. RN-B confirmed residents were added to the main floor monthly log once an antibiotic was prescribed. On 12/5/13, at 1:30 p.m. a policy for Infection control surveillance was requested. The corporate consultant RN stated the facility did not have a policy.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 14 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident room walls, bathroom walls, night stands, shelving units in bathrooms, and a catheter bag in a clean and sanitary condition for 5 of 5 residents (R46, R8, R11, R78, R42) identified with concerns in their rooms. Findings include: During the environmental tour on 12/5/13, at 10:20 a.m. with the maintenance staff (MS)-A, administrator, and housekeeper supervisor (HS)-A present, the following was observed: 1st floor: R46's room: the night stand door, drawer, and top were noted to have scratches and missing covering on the edges of the night stand. The shelving unit under the bathroom sink had missing covering/wood. On the floor in the bathroom was a basin with a catheter bag and the tubing was lying on the floor. A strong urine odor was noted in that corner of the bathroom. - At that time of the observation, the administrator stated the bathroom shelving unit should be replaced and the night stand should be repaired. - The assistant director of nursing (ADON) was contacted and verified the strong urine smell. ADON stated the storage and cleaning of the catheter bag should be reviewed. The ADON added the catheter bag should be placed off the floor in a cupboard.	F 465	**F465** **The room of R46 has had both of the night stands replaced with re-furbished ones. The chipped shelving unit in the bathroom of R46 has been removed. The bathroom shelving has been replaced with a smooth finish shelf unit. This will allow for proper storage (above the floor in clean dry container) of the catheter bag thus also eliminating the strong odor.** **The nightstand of R8 has been repaired to eliminate the scratched and missing covering.**	

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F 465	Continued From page 15 R8's room: The night stand door, drawer, and top were noted to have scratches and missing covering on the edges of the night stand. At that time the administrator stated the nightstand should be repaired. - A wall area approximately 2 feet x 3 feet area under the bathroom sink was noted to have wallpaper coming off the wall, the pipes under the sink was noted to be wet. At that time of the observation, MS-A stated a leak had been repaired "a week ago." MS-A verified there was still a slight drip. MS-A confirmed he should have repaired the leak and repaired the wallpaper. - The caulking around the base of the toilet stool was noted to have areas of missing caulk and areas of dark brown matter. MS-A stated the base of the toilet should be re-calked. 2nd floor R11's room: the right side of the room, was noted to have multiple large 4 inches x 2 inch areas of missing paint and scrapes on the plaster board. At the time of the observation, HS-A stated a recliner had been placed there and scrapped the wall. MS-A stated the wall should be repaired, that he had not received a repair slip on the area, and "any staff" could fill out a repair slip. R78's room: the bathroom walls were noted to have multiple areas of missing paint where patching had been completed, however, the areas lacked paint. At the time of the observation, HS-A stated the areas had been repaired about a year ago and needed painting. R42's room: the three level shelf below the bathroom sink was noted to have missing covering on the edges. The edges of the shelves	F 465	**The wall area approximately 2 feet by 3 feet under the bathroom sink was repaired and repaired, sealed and painted. New base molding was also installed. Maintenance director has repaired the drip from the sink. The toilet base was cleaned and new caulking installed.** **On the second floor in R11s room a repair slip has been filled out. The plasterboard areas of missing paint and scrapes were repaired, sealed and painted by our Maintenance dept.** **R78s bathroom has been checked for scratches or scrapes and completely repainted.** **The three level shelves in R42s room that had missing covering on the edges have been replaced. This new shelving unit is now easy to clean.** **A facility policy has been put in place that covers wall care/cleaning, furniture maintenance and bathroom plumbing inspection.** **Deficient practice to be corrected by January 14, 2014.** **A monthly audit will be kept of environmental room tours. These will include the Maintenance Director and Administrator.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	12/05/2013

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F 465	Continued From page 16 were coming apart and the shelf was un-cleanable. At the time of the observation, the administrator stated the shelving unit should be replaced with a new unit. A policy related to wall care/cleaning, furniture maintenance, and caulking was requested and not provided. The Catheter-leg bag cleaning policy dated 4/1/2008, indicated a catheter leg bag was to be stored when not in use in a clean and dry area.	F 465		

SUBJECT: Policy for Disposal of Used Fentanyl Patches	**Fair Oaks Lodge, Inc.** **Wadena, MN**
DEPARTMENT: Nursing	**PAGE 1 - 2**
APPPROVED BY: Tina D. Wehde, RN BSN-DON **Director of Nursing**	**EFFECTIVE: 04/01/12** **REVISED: 02/07/14-TW**

POLICY

It is the policy of this facility to properly handle and dispose of used Fentanyl (Duragesic) patches in accordance with manufacturer and FDA recommendations.

DEFINITIONS

The fentanyl transdermal system, also known as the fentanyl patch, is a narcotic (opiod) pain medicine applied to the skin for treating persistent moderate to severe pain.

There is a small number of medications that may be especially harmful and , in some cases, fatal in a single doses if they are used by someone other than the person the medicine was prescribed for. For this reason, a few medicines have specific disposal instructions that indicate they should be flushed down the toilet when they are no longer needed. When you dispose of these medicines down the sink or toilet, they cannot be accidently used by children, pets, or anyone else. (1)

Fentanyl is on the FDA list of medications recommended for disposal by flushing.

Fentanyl transdermal label directions specifically instruct disposal by flushing down the toilet.

PROCEDURE

1. Fentanyl patches are applied and removed on a schedule in accordance with specific physician order.

2. Remove the old fentanyl patch when placing the new patch.

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	245581	A. BUILDING 01 - DINING ADDITION 01 B. WING _____	12/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS LODGE	201 SHADY LANE DRIVE WADENA, MN 56482

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Fair Oaks Lodge 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	POC ok JB 2-11-14	

DC: 1-14-13

EXIT: 12-5-13

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1/6/2014 Ok
MW & ML

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/6/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING 01 - DINING ADDITION 01 B. WING _____	12/03/2013

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K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us

Fax Number 651-215-0525

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Fair Oaks Lodge was constructed at four different times. In 1995 the kitchen and dining building 02 was constructed to the west of the 1965 building and is a 2-story addition that was determined to be of Type IV(2HH) construction. It is separated with a 10 foot enclosed walkway and a 2-hour fire barrier. No sleeping rooms are in this building. The original building (02 Main Building) was constructed in 1965, was determined to be of Type II (222) construction and has a wood roof system that meets the exception to NFPA 101 Sec 19.1.6.2. In 1972 a 3-story addition was constructed to the east of the original building that is 3-story building, no basement and was determined to be of Type II (222) construction and has a wood roof system that meets the exception to NFPA 101 Sec 19.1.6.2. In 1976, a 2-story addition was constructed to the south that was determined to be of Type II(222) construction. The building is divided into 8 smoke

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K 000	Continued From page 2 zones, 3 one each level, by 1 hour fire rated barriers. The facility is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with a dry pipe system and a wet pipe system (in the 1995 addition). The facility has smoke detection in the corridor system, in all areas open to the corridor, in all common areas and in all sleeping rooms that are on the facility's fire alarm system installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm has automatic fire department notification. Automatic fire detection is installed in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 70 beds and had a census of 68 at the time of the survey. Because the original 1965 building and 1972 addition are of a different construction type than the 1995 kitchen/dining addition and are separated from each other by a 2-hour fire barrier, the facility was surveyed as 2 buildings. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by:	K 054	**Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	

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	245581	A. BUILDING 01 - DINING ADDITION 01 B. WING _____	12/03/2013

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K 054	Continued From page 3 Based on observations it was determined that one of the automatic smoke detectors, that are on the fire alarm system, is not in accordance with NFPA 72 " The National Fire Alarm Code" 1999 Edition section 2-3.5.1 nor the Minnesota State Fire Code (2007). Lack of maintenance of the smoke detectors may allow them to fail or delay alarming in a fire emergency causing a delay in the response to the fire emergency, which would negatively impact all the residents, visitors and staff in the facility. Findings include: During the facility tour on December 3, 2013 between 1:00 pm and 3:15 pm, observations by surveyor 03006, revealed that: 1) The smoke detector in the 300 office was hanging by it's wiring, and 2) The workout room that is open to the corridor by the apartment building, does not have a smoke detector in it as required by the Minnesota State Fire Code (2007) section 907.2.6.3. The Director of Maintenance verified these findings during the facility tour and with the Administrator at the exit conference.	K 054	01/14/2014 MW & ML • **K054** **The smoke detector in the 300 office has been replaced and secured. It is operational and has no exposed wiring.** **A smoke detector has been installed in the workout room that is open to the corridor by the apartment building. It is secured in place and is operational.** 12/6/14	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056	01/14/2014 MW & ML • **K056** **The missing ceiling tiles in room 322 have been replaced to meet the noted requirements. The ceiling tiles in the mechanical room have also been replaced.** 12/6/14	

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K 056	Continued From page 4 supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations it was determined that the automatic sprinkler system is not installed in accordance with NFPA 13 Standard for The Installation of Sprinkler Systems, 1999 edition. This deficient practice would allow a fire to extend above the suspended ceiling into a space that is not sprinkler protected, which will negatively impact all the residents, the visitors and the staff in these areas. Findings include: During the facility tour on December 3, 2013 between 1:00 pm and 3:15 pm, observations by surveyor 03006, revealed that ceiling tiles in room 322 and in the mechanical room are missing. The Director of Maintenance verified these findings during the facility tour and with the Administrator at the exit conference.	K 056		

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	245581	A. BUILDING 02 - MAIN BUILDING 02 B. WING _____	12/03/2013

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K 000	INITIAL COMMENTS FIRE SAFETY 02 Kitchen and Dining Addition A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Fair Oaks Lodge 02 Kitchen/Dining Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date.	K 000		

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	245581	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**12/03/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS LODGE	**201 SHADY LANE DRIVE** **WADENA, MN 56482**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Fair Oaks Lodge was constructed at four different times. In 1995 the kitchen and dining building 02 was constructed to the west of the 1965 building and is a 2-story addition that was determined to be of Type IV(2HH) construction. It is separated with a 10 foot enclosed walkway and a 2-hour fire barrier. No sleeping rooms are in this building. The original building (02 Main Building) was constructed in 1965, was determined to be of Type II (222) construction and has a wood roof system that meets the exception to NFPA 101 Sec 19.1.6.2. In 1972 a 3-story addition was constructed to the east of the original building that is 3-story building, no basement and was determined to be of Type II (222) construction and has a wood roof system that meets the exception to NFPA 101 Sec 19.1.6.2. In 1976, a 2-story addition was constructed to the south that was determined to be of Type II(222) construction. The building is divided into 8 smoke zones, 3 one each level, by 1 hour fire rated, barriers.

The facility is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with a dry pipe system and a wet pipe system (in the 1995 addition). The facility has smoke detection in the corridor system, in all areas open to the corridor, in all common areas and in all sleeping rooms that are on the facility's fire alarm system installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm has automatic fire department notification.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING 02 - MAIN BUILDING 02 B. WING _____	12/03/2013

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K 000	Continued From page 2 Automatic fire detection is installed in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 70 beds and had a census of 68 at the time of the survey. Because the original 1965 building and 1972 addition are of a different construction type than the 1995 kitchen/dining addition and are separated from each other by a 2-hour fire barrier, the facility was surveyed as 2 buildings. The requirement at 42 CFR, Subpart 483.70(a) are MET in the 02 Kitchen/Dining Building.	K 000		