#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

|  |   |  |   | ND TRANSMITTAL<br>E SURVEY AGENCY | ID: QMWJ<br>Facility ID: 00679   |  |
|--|---|--|---|-----------------------------------|--|--|
| MEDICARE/MEDICAID PROVIDER NO.<br>(L1) 245581     2.STATE VENDOR OR MEDICAID NO.<br>(L2) 719475700     5. EFFECTIVE DATE CHANGE OF OWN   |   | <ol> <li>NAME AND ADI</li> <li>(L3) FAIR OAKS</li> <li>(L4) 201 SHADY I</li> <li>(L5) WADENA, M</li> <li>PROVIDER/SUF</li> </ol>   | LODGE<br>LANE DRIVE<br>IN   |                                   | (L6) <b>56482</b>  | 4. TYPE OF ACTION:     7 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other  |
| (L9) <b>01/01/2004</b>   |   | 01 Hospital  | 05 HHA  | 09 ESRD                           | 13 PTIP 22 CLIA  | 8. Full Survey After Complaint   |
| 6. DATE OF SURVEY04/10/8. ACCREDITATION STATUS:  | 2015 (L34)<br>(L10)   | 02 SNF/NF/Dual<br>03 SNF/NF/Distinct   | 06 PRTF<br>07 X-Ray   | 10 NF<br>11 ICF/III               | 14 CORF<br>0 15 ASC  | FISCAL YEAR ENDING DATE: (L35)   |
| 0 Unaccredited 1 TJC<br>2 AOA 3 Other  |   | 04 SNF   | 08 OPT/SP   | 12 RHC                            | 16 HOSPICE   | 12/31  |
| 11LTC PERIOD OF CERTIFICATION  |   | 10. THE FACILITY   | IS CERTIFIED AS:  |                                   |  |  |
| From (a):  |   | X A. In Complian   | ce With   |                                   | And/Or Approved Waivers Of The   | e Following Requirements:  |
| To (b) :   |   | Program Re   |   |                                   | 2. Technical Personnel   | 6. Scope of Services Limit   |
| 12.Total Facility Beds   | <b>75</b> (L18)   | Compliance   | Based On:<br>cceptable POC  |                                   | 3. 24 Hour RN<br>4. 7-Day RN (Rural SNF)   |  |
| 13. Total Certified Beds   | 75 (L17)  |  | pliance with Program<br>ents and/or Applied V   |                                   | 5. Life Safety Code<br>* Code: A   | 9. Beds/Room<br>(L12)  |
| 14. LTC CERTIFIED BED BREAKDOWN  |   |  |   |                                   | 15. FACILITY MEETS   |  |
| 18 SNF 18/19 SNF   | 19 SNF  | ICF  | IID   |                                   | 1861 (e) (1) or 1861 (j) (1):  | (L15)  |
| 75<br>(L37) (L38)  | (L39)   | (L42)  | (L43)   |                                   |  |  |
| 16. STATE SURVEY AGENCY REMARK   | S (IF APPLICABLE S  | HOW LTC CANCELL  | ATION DATE)   |                                   |  |  |
|  | o (ii : ii i Eice: ii) - o  |  |   |                                   |  |  |
| See Attached Remarks   |   |  |   |                                   |  |  |
| 17. SURVEYOR SIGNATURE Date :  |   |  |   |                                   |  |  |
|  |   |  |   |                                   | 18. STATE SURVEY AGENCY AP   |  |
| 17. SURVEYOR SIGNATURE Beth Nowling, HFE   | NEII  |  | 04/20/2015  | (L19)                             | 18. STATE SURVEY AGENCY AP   |  |
|  |   |  |   | . ,                               |  | , Enforcement Specialist 05/01/2015 (L20)  |
| Beth Nowling, HFE  | PART II - TO  | BE COMPLETE<br>20. COM   |   | GIONA                             | 21. 1. Statement of Financ<br>2. Ownership/Control   | , Enforcement Specialist<br>(L20)<br>(L20)   |
| Beth Nowling, HFE  | PART II - TO  | BE COMPLETE<br>20. COM   | <b>D BY HCFA RE</b><br>PLIANCE WITH CI  | GIONA                             | Mark Meath<br>LOFFICE OR SINGLE STAT<br>21. 1. Statement of Financ   | , Enforcement Specialist<br>(L20)<br>TE AGENCY<br>ial Solvency (HCFA-2572)   |
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#### CCN: 24 5581

On April 10, 2015 a Post Certification Revisit (PCR) was completed to verify the facility had corrected deficiciencies issued pursuant to a PCR completed March 11, 2015. We presumed based on the plan of correction, that the facility had achieved substantial compliance. Based on our PCR, we determined the facility has achieved substantial compliance, effective April 6, 2015. As a result of this PCR, we discontinued the Category 1 remedy of State monitroring as of April 6, 2015.

In addition, we recommended the following action related to the remedy imposed in our letter of April 20, 2015:

Mandatory Denial of Payment for New Medicare and Medicaid Admissions (DPNA), effective April 16, 2015, be rescinded.

Since DPNA didn't go into effect into effect the facility would not be subject to a two year loss of NATCEP, effective April 16, 2015.

Refer to the CMS 2567b for health only.

Effective April 6, 2015 the facility is certified for 75 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245581

May 1, 2015

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 April 6, 2015 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 Health Regulation Division Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

## NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electronically Delivered April 20, 2015

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

RE: Project Number S5581024

Dear Mr. Blanchard:

On April 20, 2015, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That notice imposed a daily fine in the amount of \$300.00.

On April 10, 2015, an acknowledgement was received by the Department stating that the violation(s) had been corrected. A reinspection was held on April 10, 2015 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$300.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$156.60, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of **\$456.60** within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health Health Regulation Division 85 East Seventh Place Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Attn: Penalty Assessment Deposit Staff Fair Oaks Lodge April 20, 2015 Page 2

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.

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

Sincerely,

-Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Program Assurance Unit Penalty Assessment Deposit Staff

origRevisitLicPATAltr



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 20, 2015

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

RE: Project Number S5581024

Dear Mr. Blanchard:

On March 16, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective March 21, 2015. (42 CFR 488.422)

On March 16, 2015, this Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred and authorized this Department to inform you that the following enforcement remedy be imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective April 16, 2015. (42 CFR 488.417 (b))

Also, this Department notified you in our letter of March 16, 2015, 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 April 16, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on January 16, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 11, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On April 10, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 11, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 6, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 11, 2015, as of

Fair Oaks Lodge April 20, 2015 Page 2

April 6, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 6, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 16, 2015. 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 April 16, 2015, 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 April 16, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 16, 2015, is to be rescinded.

In our letter of March 16, 2015, 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 April 16, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 6, 2015, 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 visit with the President of your facility's Governing Body.

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

Sincerely,

## -Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697 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 /<br>Identification Number<br>245581 | (Y2) Multiple Construction<br>A. Building<br>B. Wing |  | (Y3) Date of Revisit<br>4/10/2015 |
|-----------------|---|--|--|-----------------------------------|
| Name            | of Facility   |  | Street Address, City, State, Zip Code    |                                   |
| FAIR OAKS LODGE |   |  | 201 SHADY LANE DRIVE<br>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                  | F0279                             | Correction<br>Completed<br>_04/06/2015 | ID Prefix                  | F0323              | Correction<br>Completed<br>04/06/2015 | ID Prefix _                              |      | Correction<br>Completed |
| Reg. #<br>LSC              | 483.20(d), 483.20(k)(1)           | -                                      | Reg. #<br>LSC              | 483.25(h)          |                                       | Reg. # _<br>LSC _                        |      |                         |
| ID Prefix<br>Reg. #<br>LSC |                                   |  | Reg. #                     |                    | Correction<br>Completed               | ID Prefix                                |      | Correction<br>Completed |
| ID Prefix<br>Reg. #<br>LSC |                                   | -                                      | ID Prefix<br>Reg. #<br>LSC |                    | Correction<br>Completed               | Reg. #                                   |      |                         |
| ID Prefix<br>Reg. #<br>LSC |                                   | Correction<br>Completed                |                            |                    | Correction<br>Completed               |  |      |                         |
| ID Prefix<br>Reg. #<br>LSC |                                   |  | Reg. #                     |                    |                                       | D#                                       |      |                         |
|                            |                                   |  |                            |                    |                                       |  |      |                         |
| Reviewed By                | Reviewed                          | Ву                                     | Date:                      | Signature of Surve | yor:                                  |  | Date | :                       |
| State Agency               | , PK/m                            | m                                      | 04/20/20                   | 015                | 34088                                 |  | 0    | 4/10/2015               |
| Reviewed By<br>CMS RO      | Reviewed                          | Ву                                     | Date:                      | Signature of Surve | yor:                                  |  | Date | :                       |
| Followup to                | Survey Completed on:<br>1/16/2015 |  |                            | -                  |                                       | eficiencies. Was a<br>(CMS-2567) Sent to | •    | S NO                    |

#### State Form: Revisit Report

| (Y1)            | Provider / Supplier / CLIA /<br>Identification Number<br>00679 | <b>(Y2) Multiple Construction</b><br>A. Building<br>B. Wing | A. Building                              |  |
|-----------------|--|---|--|--|
| Name            | of Facility  |   | Street Address, City, State, Zip Code    |  |
| FAIR OAKS LODGE |  |   | 201 SHADY LANE DRIVE<br>WADENA, MN 56482 |  |

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item     | (Y5                    | i) Date              | (Y4) Item     | (Y5)               | Date           | (Y4) Item            | (Y5)               | Date       |
|---------------|------------------------|----------------------|---------------|--------------------|----------------|----------------------|--------------------|------------|
|               |                        | Correction           |               |                    | Correction     |                      |                    | Correction |
| ID Prefix     | 20560                  | Completed 04/06/2015 | ID Prefix     |                    | Completed      | ID Prefix            |                    | Completed  |
|               | MN Rule 4658.0405 Subp | _                    | Reg. #        |                    | -              | Reg. #               |                    |            |
|               |                        | _                    | LSC           |                    |                | LSC                  |                    |            |
|               |                        |                      |               |                    |                |                      |                    |            |
|               |                        | Correction           |               |                    | Correction     |                      |                    | Correction |
| ID Prefix     |                        | Completed            | ID Prefix     |                    | Completed      | ID Prefix            |                    | Completed  |
|               |                        | _                    |               |                    | -              |                      |                    |            |
| Reg. #<br>LSC |                        | _                    | Reg. #<br>LSC |                    |                | Reg. #               |                    |            |
|               |                        |                      |               |                    |                |                      |                    |            |
|               |                        | Correction           |               |                    | Correction     |                      |                    | Correction |
|               |                        | Completed            | ID Desfer     |                    | Completed      |                      |                    | Completed  |
|               |                        | _                    |               |                    |                |                      |                    |            |
| Reg. #        |                        | _                    | Reg. #        |                    |                | Reg. #               |                    |            |
|               |                        | _                    |               |                    |                |                      |                    |            |
|               |                        | Correction           |               |                    | Correction     |                      |                    | Correction |
|               |                        | Completed            |               |                    | Completed      |                      |                    | Completed  |
| ID Prefix     |                        | _                    | ID Prefix     |                    | -              | ID Prefix            |                    |            |
| Reg. #        |                        | _                    | Reg. #        |                    |                | Reg. #               |                    |            |
| LSC           |                        | _                    | LSC           |                    |                |                      |                    |            |
|               |                        | Correction           |               |                    | Correction     |                      |                    | Correction |
|               |                        | Completed            |               |                    | Completed      |                      |                    | Completed  |
| ID Prefix     |                        | _                    | ID Prefix     |                    | -              | ID Prefix            |                    |            |
| Reg. #        |                        | _                    | Reg. #        |                    |                | Reg. #               |                    |            |
| LSC           |                        | _                    | LSC           |                    |                | LSC _                |                    |            |
|               |                        |                      |               |                    |                |                      |                    |            |
| Reviewed By   | Reviewed               | Ву                   | Date:         | Signature of Surve | yor:           |                      | Date               | 9:         |
| State Agency  | PK/m                   | m                    | 04/20/2015    |                    | 340            | 88                   | 04                 | 4/10/2015  |
| Reviewed By   | v Reviewed             | Ву                   | Date:         | Signature of Surve | yor:           |                      | Date               | 9:         |
| CMS RO        |                        |                      |               |                    |                |                      |                    |            |
| Followup to   | Survey Completed on:   |                      |               |                    |                | Deficiencies. Was a  |                    |            |
|               | 1/16/2015              |                      |               | Uncorrecte         | d Deficiencies | s (CMS-2567) Sent to | o the Facility? YE | S NO       |
| STATE FORM    | I: REVISIT REPORT (    | 5/99)                |               | Page 1 of 1        |                |                      | Event ID: QMW      | J13        |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: OMWJ PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00679 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) FAIR OAKS LODGE (L1) 245581 1. Initial 2. Recertification (L4) 201 SHADY LANE DRIVE 2 STATE VENDOR OR MEDICAID NO 3. Termination 4. CHOW (L6) 56482 (L2) 719475700 (L5) WADENA, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 02 7. PROVIDER/SUPPLIER CATEGORY (L7) 8. Full Survey After Complaint (L9) 01/01/2004 01 Hospital **05 HHA** 09 ESRD **13 PTIP** 22 CLIA 02 SNF/NF/Dual 06 PRTF 6 DATE OF SURVEY 03/11/2015 (L34) 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35) 8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 11 ICF/IID (L10) 07 X-Ray 15 ASC 12/31 0 Unaccredited 1 TJC 04 SNF 12 RHC 16 HOSPICE 08 OPT/SP 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10. THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: From (a) : A. In Compliance With Program Requirements Technical Personnel \_\_\_\_\_ 6. Scope of Services Limit То (b) : Compliance Based On: \_ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 12. Total Facility Beds 1. Acceptable POC 75 (L18) 8. Patient Room Size 5. Life Safety Code \_\_\_\_\_9. Beds/Room X B. Not in Compliance with Program 13 Total Certified Beds (L17) 75 (L12)Requirements and/or Applied Waivers: \* Code R\* 14. LTC CERTIFIED BED BREAKDOWN 15 FACILITY MEETS 18/19 SNF ICF IID (L15) **18 SNF 19 SNF** 1861 (e) (1) or 1861 (j) (1): 75 (L37) (L38) (L39) (L42) (L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date Date: Lyla Burkman, Unit Supervisor mark meath, Enforcement Specialist 03/25/2015 04/09/2015 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 21 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above : Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY 00 INVOLUNTARY 11/01/1991 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L41) (L25) (L24) 03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS OTHER 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change 00-Active (L44) (L27) B. Rescind Suspension Date: (L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31)

| DEPARTMENT OF HEALTH AND HU | MAN SERVICES                                | <b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b> |                    |  |
|-----------------------------|---|---|--------------------|--|
|                             | MEDICARE/MEDICAID CERTIFICATION AND TRAN    | ISMITTAL  | ID: QMWJ           |  |
|                             | PART I - TO BE COMPLETED BY THE STATE SURVE | YAGENCY   | Facility ID: 00679 |  |
| C&T REMARKS - CMS 1539 FORM | STATE AGENCY REMARKS                        |   |                    |  |

#### CCN: 24 5581

On March 11, 2015 a Post Certification Revisit (PCR) was completed to verify the facility had corrected deficiciencies issued pursuant to the January 16, 2015 standard survey. We presumed based on the plan of correction, that the facility had achieved substantial compliance. Based on our PCR, we determined the facility had not achieved substantial compliance. The most serious deficiency at the time of the PCR was found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate kjeopardy (Level D). As a result the facility has not achieve substantial compliance. This Department imposed the following Cateogry 1 remedy:

- State Monitoring effective March 21, 2015 (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V office, CMS concurred and authorized this Department to notify the facility of the following remedy imposition:

- Mandatory Denial of Payment for new Medicare and Medicaid Admissions (DPNA), effective April 16, 2015 (42 CFR 488.417(b))

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP, effective April 16, 2015.

Refer to the CMS 2567b and CMS 2567 along with the provider's plan of correction. PCR to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

#### RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On April 10, 2015,

I, STEFAN STAMENICOICS, ADMIN DESIGNED, received

(Name)(Please Print) (Title)(Please Print) the Notice of Penalty Assessment dated and licensing orders issued to:

> Fair Oaks Lodge 201 Shady Lane Drive Wadena, MN 56482

The Penalty Assessments and licensing orders attached hereto have been corrected as of April 10, 2015.

Signed: STEPAN STAMENKOVIC, Marin DESKINGE, Date 4/10/15 (Name)(Please Print) (Title)(Please Print)

#### DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On April 10, 2015, I, <u>Froh Nowling KN</u>, Loc Health Regulation Division,

(Name)(Please Print) (Title)(Please Print) Minnesota Department of Health, delivered the Notice of Penalty Assessment dated and issued to:

> Fair Oaks Lodge 201 Shady Lane Drive Wadena, MN 56482

The Notice of Penalty Assessment was handed to <u>Stefen Stamkovic</u> <u>Admin DigNl</u>, Date <u>4/10/15</u> (Name)(Please Print) (Title)(Please Print)

10(1 Signed: VC , Date Name)(Please

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#### Protecting, Maintaining and Improving the Health of Minnesotans NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on April 10, 2015.

April 10, 2015

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

Re: Project # S5581024

Dear Mr. Blanchard:

On March 11, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 16, 2015 with orders received by you electronically on March 16, 2015.

State licensing orders issued pursuant to the last survey completed on January 16, 2015 and found corrected at the time of this March 11, 2015 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on January 16, 2015, found not corrected at the time of this March 11, 2015 revisit and subject to penalty assessment are as follows:

#### 20560 -- MN Rule 4658.0405 Subp. 2 -- Comprehensive Plan Of Care; Contents - \$300.00

The details of the violations noted at the time of this revisit completed on March 11, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to:

Pam Kerssen, RN, APM Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: pam.kerssen@state.mn.us Telephone: (218) 308-2129 Fax: (218) 308-2122 When the Department receives notification that the orders are corrected, a reinspection will be conducted to

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Fair Oaks Lodge April 10,2015 Page 2

verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

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 Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

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#### Protecting, Maintaining and Improving the Health of Minnesotans NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on April 10, 2015.

April 10, 2015

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

Re: Project # S5581024

Dear Mr. Blanchard:

On March 11, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 16, 2015 with orders received by you electronically on March 16, 2015.

State licensing orders issued pursuant to the last survey completed on January 16, 2015 and found corrected at the time of this March 11, 2015 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on January 16, 2015, found not corrected at the time of this March 11, 2015 revisit and subject to penalty assessment are as follows:

#### 20560 -- MN Rule 4658.0405 Subp. 2 -- Comprehensive Plan Of Care; Contents - \$300.00

The details of the violations noted at the time of this revisit completed on March 11, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to:

Pam Kerssen, RN, APM Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: pam.kerssen@state.mn.us Telephone: (218) 308-2129 Fax: (218) 308-2122 When the Department receives notification that the orders are corrected, a reinspection will be conducted to

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Fair Oaks Lodge April 10,2015 Page 2

verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

## If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

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 Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 16, 2015

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

RE: Project Number S5581024

Dear Mr. Blanchard:

On February 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 16, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On March 11, 2015, the Minnesota Department of Health and on February 26, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 16, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 16, 2015. The deficiencies not corrected are as follows:

### F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans

In addition, at the time of this revisit, we identified the following deficiency:

### F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective March 21, 2015. (42 CFR 488.422)

In addition, 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 April 16, 2015. (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 April 16, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 16, 2015. 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 April 16, 2015. 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.

## 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:

Pam Kerssen, RN, APM Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: pam.kerssen@state.mn.us

Telephone: (218) 308-2129 Fax: (218) 308-2122

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 remedy be imposed:

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

Failure to submit an acceptable ePoC 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 ePoC for their respective deficiencies (if any) is acceptable.

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

# 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 July 16, 2015 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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 related to this eNotice.

Sincerely, Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

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|                          |  | AND HUMAN SERVICES   |                             | FO   | ED: 04/08/2015<br>RM APPROVED             |
|--------------------------|--|--|-----------------------------|--|---|
| STATEMENT                | TOF DEFICIENCIES   | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION (X3)  | NO. 0938-0391<br>DATE SURVEY<br>COMPLETED |
|                          | PROVIDER OR SUPPLIER<br>KS LODGE   | 245581   | B. WING<br>S                |  | R<br>03/11/201 <u>5</u>                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                |
| {F 000}                  | completed on 3/11/<br>were corrected car   | tification revisit (PCR) was<br>15. The certification tags that<br>be found on the CMS2567B.   | {F 000}                     |  |   |
|                          | and a new tag was<br>PCR which is locat  | that was not found corrected<br>also issued at the time of the<br>ed on the CMS2567.<br>nrolled in ePOC, your  |                             |  |   |
|                          | signature is not rec<br>page of the CMS-2  | uired at the bottom of the first<br>567 form. Your electronic<br>POC will be used as   |                             |  |   |
| {F 279}<br>SS=D          | on-site revisit of yo validate that substa   |  | {F 279}                     |  | 4/6/15                                    |
|                          |  | the results of the assessment<br>and revise the resident's<br>n of care.   |                             |  |   |
|                          | plan for each resid<br>objectives and time<br>medical, nursing, a                        | evelop a comprehensive care<br>ent that includes measurable<br>etables to meet a resident's<br>nd mental and psychosocial<br>ntified in the comprehensive  |                             |  |   |
|                          | to be furnished to a<br>highest practicable<br>psychosocial well-b<br>§483.25; and any s | t describe the services that are<br>attain or maintain the resident's<br>physical, mental, and<br>being as required under<br>services that would otherwise |                             |  |   |
|                          | director's or provid   | DER/SUPPLIER REPRESENTATIVE'S SIGI   | NATURE                      | TITLE 03,  | (X6) DATE<br>/19/2015                     |

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.

| CENTE                    | RS FOR MEDICA   | TH AND HUMAN SERVICES<br>RE & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA  | . ,                 | PRINTED: 04,<br>FORM APF<br>OMB NO. 093<br>LE CONSTRUCTION (X3) DATE SU   | PROVEE<br><u>38-0391</u><br>RVEY |  |
|--------------------------|---|---|---------------------|---|----------------------------------|--|
|                          | OF CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING         | TRIAR   | R<br>03/11/201 <u>5</u>          |  |
|                          | KS LODGE  |   | Г - 1 - 2           | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |                                  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>MPLETION<br>DATE         |  |
| {F 279}                  | due to the reside<br>§483.10, includir<br>under §483.10(b<br>This REQUIREM<br>by:<br>Based on obser<br>review, the facilit<br>written care plan<br>1 of 1 resident (F<br>dysphagia (difficit<br>therapy recomment<br>Findings includes<br>R49's Admission<br>R49 had diagnos<br>history of cerebra<br>and malaise and<br>Minimum Data S<br>indicated R49 ha | <ul> <li>\$483.25 but are not provided<br/>ont's exercise of rights under<br/>on the right to refuse treatment<br/>of the right to refuse treatme</li></ul> | {F 279]             | F279<br>Resident #49 suffered no ill effects from<br>being assisted by a visitor at meal time.<br>Resident #49 has had his Care Plan<br>reviewed and revised to reflect SLP<br>recommendations and swallowing<br>disorders.<br>Any resident needing assistance with<br>meals has the potential to be affected by<br>this practice.<br>*Nursing staff is to receive education on<br>not allowing visitors to feed/assist<br>residents with meals<br>*DON/Designee will update/review all<br>Care Plans of current residents with |                                  |  |
|                          | On 3/10/15, at 5:<br>R49 was observe<br>cheese sandwich<br>visitor was obser<br>by holding the sa<br>bringing it to R49<br>R49 to quickly ea  | 24 p.m. during the evening meal,<br>ed to be served a meat and<br>n, which was a special request. A<br>rved to assist R49 to eat the meal<br>andwich in her bare hands and<br>b's mouth. The visitor assisted<br>at the sandwich and R49<br>ank 100% of all the fluid that was  |                     | specialized feeding programs that<br>recommendations are appropriately<br>included into Care Plan<br>*DON/Designee will assure process is<br>completed and will audit Care Plans<br>weekly x 3months to assure system is<br>intact<br>*Findings from audits will be reviewed at<br>QAA x 3 months to assure trends or<br>negative findings of audits are corrected.   |                                  |  |

Facility ID: 00679

| STATEMENT                | TOF DEFICIENCIES   | RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIF<br>A. BUILDING |  | (X3) DA              | 0. 0938-039<br>TE SURVEY<br>MPLETED<br>R |
|--------------------------|--|--|----------------------------|--|----------------------|--|
| NAME OF I                | PROVIDER OR SUPPLI   | <b>245581</b><br>ER  | B. WING                    | STREET ADDRESS, CITY, STATE, ZIP CODI  | – 03/11/201 <u>5</u> |  |
| FAIR OA                  | KS LODGE   |  |                            | 201 SHADY LANE DRIVE<br>WADENA, MN 56482   |                      |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEI   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE              | (X5)<br>COMPLETIC<br>DATE                |
| {F 279}                  | assessment date<br>an acute CVA (st<br>10/9/14. While a<br>swallow complet<br>oral pharyngeal o<br>bolus control in o<br>valleculae. Decre<br>had silent aspira<br>liquids, and hone<br>thick liquids pt ha<br>noted. Upon R49 | page 2<br>erapy progress notes and<br>ed 10/17/14, revealed R49 had<br>roke) and was hospitalized on<br>t the hospital R49 had a video<br>ed which indicated "mod-severe<br>dysphagia characterized by poor<br>oral cavity with pooling in the<br>eased hyolaryngeal elevation. Pt<br>tion of thin liquids, nectar thick<br>ey thick liquids. With pudding<br>ad penetration with no cough<br>d's readmission to the nursing<br>ipated in speech therapy until | {F 279                     | Corrective Action is to be com<br>4/6/15   | bleted by:           |  |
|                          | 11/12/14, from P<br>dietary departme<br>"Pt had made the<br>regular texture /t<br>drink unsupervis<br>1. Provide small   | al Communication form dated<br>RO REHAB to nursing and<br>ents the following was identified:<br>e educated decision to return to<br>hin liquids. Pt is not to eat and<br>ed. When assisting with feeding:<br>bites/sips one at a time at a slow<br>has swallowed prior to offering   |                            |  |                      |  |
|                          | pathologist (SLP<br>she stated R49 h<br>2014, and as a h<br>aspirated food an<br>she worked with<br>exercises to help<br>SLP stated that h<br>according to the   | with the speech language<br>) on 03/11/2015, at 8:30 a.m.<br>had an acute CVA in October<br>result of this stroke R49 silently<br>nd liquids. The SLP stated that<br>R49 post hospitalization and did<br>o increase swallowing ability. The<br>R49 should be assisted to eat<br>written instructions she had<br>sing and dietary staff. The SLP  |                            |  |                      |  |

Facility ID: 00679

If continuation sheet Page 3 of 8

| CENTER<br>TATEMENT       | RS FOR MEDICAR   | HAND HUMAN SERVICES         RE & MEDICAID SERVICES         (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPL        | E CONSTRUCTION   | FORM<br>OMB NO<br>(X3) DAT | 04/08/201<br>APPROVE<br>0.0938-039<br>FE SURVEY |
|--------------------------|--|--|---------------------|--|----------------------------|---|
| ND PLAN C                | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING         |  | A I                        | MPLETED<br>R                                    |
|                          | PROVIDER OR SUPPLIE  | <b>245581</b><br>B   | B. WING             | TREET ADDRESS, CITY, STATE, ZIP CODE   |                            | /11/201 <u>5</u>                                |
|                          | KS LODGE   |  | 2                   | 01 SHADY LANE DRIVE<br>VADENA, MN 56482  |                            |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                    | (X5)<br>COMPLETIO<br>DATE                       |
| {F 279}                  | using straws to d<br>was contraindicat<br>deficits R49 expe<br>she had not provi<br>regarding the risk | as not aware that R49 had been<br>rink from, and that using a straw<br>ted for the type of swallowing<br>erienced. The SLP stated that<br>ided R49 with education<br>to of using straws because she<br>aff were providing R49 with | {F 279}             |  |                            |   |
|                          | identification that<br>problems and had<br>instructions for as<br>small bites/sips o                   | lated 3/10/15, lacked<br>R49 had any swallowing<br>d not included the SLP<br>ssisting R49 to eat (1. Provide<br>ine at a time at a slow rate 2.<br>vallowed prior to offering another  |                     |  |                            |   |
| F 323<br>SS=D            | 3/10/15, at 7:19 p<br>plan had not inclu<br>SLP regarding as<br>dysphagia diagno<br>483.25(h) FREE     |  | F 323               |  |                            | 4/6/15  |
|                          | environment rem<br>as is possible; an  | ensure that the resident<br>ains as free of accident hazards<br>id each resident receives<br>ision and assistance devices to<br>5.   |                     |  |                            |   |
|                          | This REQUIREM by:  | ENT is not met as evidenced  |                     |  |                            |   |

If continuation sheet Page 4 of 8

|                          | RS FOR MEDICA  | RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPI        | E CONSTRUCTION   |  | APPROVEE<br>0938-039 <sup>-</sup><br>survey |
|--------------------------|--|--|---------------------|--|--|---|
|                          | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING         |  | COMPLETED  |   |
|                          |  |  |                     |  | E F  | 1   |
|                          |  | 245581   | B. WING             |  | 03/1   | 11/2015                                     |
| NAME OF I                | PROVIDER OR SUPPLI   | ER .   | S                   | TREET ADDRESS, CITY, STATE, ZIP COD  | E  |   |
| FAIR OA                  | KS LODGE   |  |                     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482  |  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEI   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)  | IOULD BE   | (X5)<br>COMPLETION<br>DATE                  |
| F 323                    | Continued From   | page 4   | F 323               |  |  |   |
| 1 020                    | Based on obser<br>review, the facilit<br>staff assisted du<br>speech therapy r<br>resident (R49) in  | vation, interview and document<br>y failed to ensure that trained<br>ring dinning according to the<br>recommendations for 1 of 1<br>the sample who had dysphagia<br>ving) and was observed to be   | F 323               | F323<br>Resident #49 suffered no ill ef<br>being assisted by a visitor at n<br>Visitor will no longer feed resid<br>and resident s Care Plan has<br>reviewed and revised to reflec<br>recommendations for specific   | neal time.<br>lent #49<br>been<br>t SLP  |   |
|                          | R49 had diagnos  | Record dated 3/10/15, indicated<br>ses of contracture of the hands,<br>al infarct (stroke), type II  |                     | cues.<br>All resident requiring assistant<br>feeding has the potential to be<br>this practice.<br>*Nursing staff is to receive edu<br>not allowing visitors to feed/as   | affected by<br>ucation on  |   |
|                          | R49's quarterly N<br>12/1/14, revealed   | Ainimum Data Set (MDS) dated<br>d R49 had very little cognitive<br>had trouble with coughing or  |                     | residents with meals<br>*Visitor was educated on not b<br>feed family member or other r<br>without skilled training  | being able to<br>esidents  |   |
|                          | R49 was observed<br>motion in both up<br>adaptive plastic g<br>and juice with str<br>to drink independ<br>sucking up the fl<br>having to pick up<br>served a meat at<br>a personal reque<br>R49's sandwich<br>R49's mouth allo<br>holding the sand | 24 p.m. during the evening meal,<br>ed to have limited range of<br>oper extremities and two large<br>glasses filled with chocolate milk<br>raws inserted. R49 was observed<br>dently by bending over and<br>uid through the straw without<br>o the glass and hold it. R49 was<br>nd cheese sandwich, which was<br>est. A visitor was observed to hold<br>in her bare hands, bringing it to<br>wing him to eat it. With the visitor<br>wich, R49 was observe to quickly<br>and independently drink 100% |                     | *Any family members that wish<br>their own family member with<br>have education completed to a<br>understand risk and benefits of<br>their family member and have<br>check off by an RN or Speech<br>*Audits will take place 3 times,<br>assure that a system is in place<br>staff education was effective<br>*Findings from audits will be re<br>QAA x 3 months to assure tree<br>negative findings of audits are<br>Corrective Action is to be com<br>4/6/15 | meals will<br>assure they<br>of feeding<br>a skilled<br>Therapist<br>week to<br>be to assure<br>eviewed at<br>nds or<br>corrected. |   |

Facility ID: 00679

|                          |  | AND HUMAN SERVICES   |                             |  | FORM  | 04/08/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-----------------------------|--|-------|-------------------------------------|
|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   | СОМ   | E SURVEY<br>IPLETED                 |
|                          |  | 245581   | B. WING                     |  |       | R<br>11/2015                        |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                             | TREET ADDRESS, CITY, STATE, ZIP CODE   |       |                                     |
| FAIR OA                  | KS LODGE   |  |                             | 01 SHADY LANE DRIVE  |       | _                                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | Continued From pa  | age 5  | F 323                       |  |       |                                     |
|                          | had frequently assi<br>meal because she<br>facility nursing assi<br>because he was as<br>wait for a nursing a  | 0 p.m. the visitor stated she<br>isted R49 to eat his evening<br>thought it was helpful to the<br>istants and also helped R49<br>ssisted sooner than if he had to<br>assistant to assist him. The<br>hat she had not been trained<br>eating.   |                             |  |       |                                     |
|                          | had assisted R49 t<br>days per week. She<br>appetite and was a<br>stopping him. " Th<br>approximately twice<br>was " choking " at<br>like it went down th<br>visitor stated she h  | 1 p.m. the visitor stated she<br>o eat dinner approximately four<br>e stated R49 had a good<br>a "quick " eater with " no<br>e visitor also stated<br>e a week R49 would act like he<br>fter drinking liquids too fast and<br>he wrong tube. In addition, the<br>had not received training or<br>to assist R49 to eat.   |                             |  |       |                                     |
|                          | assessment dated<br>an acute CVA (stro<br>10/9/14. While at th<br>swallow completed<br>oral pharyngeal dys<br>bolus control in ora<br>valleculae. Decreas<br>had silent aspiratio<br>liquids, and honey<br>thick liquids pt had<br>noted. Upon R49's | apy progress notes and<br>10/17/14, revealed R49 had<br>ke) and was hospitalized on<br>he hospital R49 had a video<br>which indicated "mod-severe<br>sphagia characterized by poor<br>al cavity with pooling in the<br>sed hyolaryngeal elevation. Pt<br>of thin liquids, nectar thick<br>thick liquids. With pudding<br>penetration with no cough<br>readmission to the nursing<br>ated in speech therapy until |                             |  |       |                                     |

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|                          |  | H AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                             |  | FORM                          | 04/08/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-----------------------------|--|-------------------------------|-------------------------------------|
| -                        | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245581  | B. WING                     |  |                               | २<br><b>11/2015</b>                 |
| NAME OF                  | PROVIDER OR SUPPLIER   |   | S                           | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               | 1/2013                              |
| FAIR OA                  | KS LODGE   |   |                             | 01 SHADY LANE DRIVE<br>VADENA, MN 56482                                      |                               |                                     |
| 0(0)15                   |  | ATEMENT OF DEFICIENCIES   |                             | PROVIDER'S PLAN OF CORRECT   |                               | ()(5)                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE                        | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | Continued From pa  | age 6   | F 323                       |  |                               | l                                   |
|                          | Communication da<br>REHAB to nursing<br>following was ident<br>educated decision<br>liquids. Pt is not to<br>When assisting wit<br>bites/sips one at a<br>has swallowed price<br>Review of a Reside<br>Communication for<br>REHAB to nursing<br>indicated R49 and<br>decision for a diet   | ent Referral Interdepartmental<br>ated 11/12/14, from PRO<br>and dietary departments the<br>tified: "Pt had made the<br>to return to regular texture /thin<br>eat and drink unsupervised.<br>th feeding: 1. Provide small<br>time at a slow rate 2 Ensure pt<br>or to offering another bite/drink.<br>ent Referral Interdepartmental<br>mm dated 11/3/14, from PRO<br>and dietary departments<br>his wife made the informed<br>change to puree textures/thin<br>penefit form had been signed.   |                             |  |                               |                                     |
|                          | pathologist (SLP) s<br>October 2014, and<br>silently aspirated for<br>stated she worked<br>and did exercises t<br>ability. The SLP sta<br>follow-up video swa<br>his diet but R49 ch<br>swallow study and<br>SLP stated she hav<br>regarding the risks<br>doing a video swal<br>should be assisted<br>instructions she hav<br>dietary staff. The S<br>R49 had been usin<br>using a straw was | 0 a.m. the speech language<br>stated R49 had an acute CVA in<br>d as a result of this stroke R49<br>ood and liquids. The SLP<br>I with R49 post hospitalization<br>to help increase swallowing<br>ated she had recommended a<br>vallow study to advance R49 on<br>hose to forego the video<br>return to a normal diet. The<br>d provided much education<br>s of advancing the diet without<br>llow first. The SLP stated R49<br>d to eat according to the written<br>ad provided the nursing and<br>SLP stated she was not aware<br>ng straws to drink from and that<br>contraindicated for the type of<br>s R49 experienced. The SLP |                             |  |                               |                                     |

Facility ID: 00679

If continuation sheet Page 7 of 8

|  |  | HAND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                     |  | FORM                          | 04/08/2015<br>APPROVED<br>0938-0391 |
|--|--|--|---------------------|--|-------------------------------|-------------------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA<br>AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|  |  | 245581   | B. WING             |  |                               | २<br><b>11/2015</b>                 |
| NAME OF  | PROVIDER OR SUPPLIER   |  |                     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FAIR OA  | KS LODGE   |  |                     | 01 SHADY LANE DRIVE  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE                        | (X5)<br>COMPLETION<br>DATE          |
| F 323  | regarding the risk of<br>was not aware star<br>straws to drink thro<br>R49's care plan da<br>it did had not ident<br>nor any swallowing<br>included the SLP in<br>eat (1. Provide sm<br>slow rate 2. Ensure<br>offering another bit<br>On 3/10/15, at 7:19<br>(DON) stated she<br>was assisting R49<br>on most days. The<br>visitor had not bee<br>eating, and the car | t provided R49 with education<br>of using straws because she<br>ff were providing R49 with<br>ough.<br>Ated 3/10/15, was reviewed and<br>ified R49's dysphagia diagnosis<br>g problems and had not<br>nstructions for assisting R49 to<br>all bites/sips one at a time at a<br>e pt has swallowed prior to<br>te/drink.)<br>9 a.m. the director of nursing<br>was not aware that a visitor<br>to eat during the evening meal,<br>e DON confirmed that this<br>on trained to assist R49 with<br>re plan had not included<br>en by the SLP regarding | F 323               |  |                               |                                     |

Facility ID: 00679

If continuation sheet Page 8 of 8

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 /<br>Identification Number<br>245581 | (Y2) Multiple Construction<br>A. Building<br>B. Wing |  | (Y3) Date of Revisit<br>3/11/2015 |
|-----------------|---|--|--|-----------------------------------|
| Name            | of Facility   |  | Street Address, City, State, Zip Code    |                                   |
| FAIR OAKS LODGE |   |  | 201 SHADY LANE DRIVE<br>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) | ltem      |           | (Y5)          | Date                                  | (Y4)        | ltem             | 1         | (Y5)  | Date                                  |
|----------------------------------|------------------|-------|---------------------------------------|------|-----------|-----------|---------------|---------------------------------------|-------------|------------------|-----------|-------|---------------------------------------|
| ID Prefix                        | F0282            |       | Correction<br>Completed<br>02/16/2015 |      | ID Prefix | F0309     |               | Correction<br>Completed<br>02/16/2015 |             | ID Prefix        | F0314     |       | Correction<br>Completed<br>02/16/2015 |
|                                  | 483.20(k)(3)(ii) |       |                                       |      | Reg. #    |           |               | -                                     |             |                  | 483.25(c) |       | _                                     |
| LSC                              | 403.20(R)(3)(1)  |       |                                       |      | LSC       | 403.23    |               |                                       |             | LSC              |           |       | _                                     |
|                                  |                  |       |                                       |      |           |           |               |                                       |             |                  |           |       |                                       |
|                                  |                  |       | Correction                            |      |           |           |               | Correction                            |             |                  |           |       | Correction                            |
|                                  |                  |       | Completed                             |      |           |           |               | Completed                             |             |                  |           |       | Completed                             |
| ID Prefix                        | F0315            |       | 02/16/2015                            |      | ID Prefix |           |               | -                                     |             | ID Prefix        |           |       |                                       |
| Reg. #                           | 483.25(d)        |       |                                       |      | Reg. #    |           |               |                                       |             | Reg. #           |           |       |                                       |
| LSC                              |                  |       |                                       |      | LSC       |           |               |                                       |             | LSC              |           |       | _                                     |
|                                  |                  |       |                                       |      |           |           |               |                                       |             |                  |           |       |                                       |
|                                  |                  |       | Correction                            |      |           |           |               | Correction                            |             |                  |           |       | Correction                            |
|                                  |                  |       | Completed                             |      |           |           |               | Completed                             |             |                  |           |       | Completed                             |
| ID Prefix                        |                  |       |                                       |      | ID Prefix |           |               | -                                     |             | ID Prefix        |           |       | _                                     |
| Reg. #                           |                  |       |                                       |      | Reg. #    |           |               |                                       |             | Reg. #           |           |       | _                                     |
| LSC                              |                  |       |                                       |      | LSC       |           |               |                                       |             | LSC              |           |       | _                                     |
|                                  |                  |       | <b>a</b> "                            |      |           |           |               |                                       |             |                  |           |       | <b>o</b> "                            |
|                                  |                  |       | Correction                            |      |           |           |               | Correction                            |             |                  |           |       | Correction                            |
| ID Prefix                        |                  |       | Completed                             |      | ID Prefix |           |               | Completed                             |             | ID Prefix        |           |       | Completed                             |
| Reg. #                           |                  |       |                                       |      | Reg. #    |           |               | -                                     |             |                  |           |       |                                       |
| LSC                              |                  |       |                                       |      |           |           |               |                                       |             | LSC              |           |       | _                                     |
|                                  |                  |       |                                       |      |           |           |               |                                       |             |                  |           |       |                                       |
|                                  |                  |       | Correction                            |      |           |           |               | Correction                            |             |                  |           |       | Correction                            |
|                                  |                  |       | Completed                             |      |           |           |               | Completed                             |             |                  |           |       | Completed                             |
| ID Prefix                        |                  |       |                                       |      | ID Prefix |           |               | -                                     |             | ID Prefix        |           |       |                                       |
| Reg. #                           |                  |       |                                       |      | Reg. #    |           |               |                                       |             | Reg. #           |           |       |                                       |
| LSC                              |                  |       |                                       |      | LSC       |           |               |                                       |             | LSC              |           |       | _                                     |
|                                  |                  |       |                                       |      |           |           |               |                                       |             |                  |           |       |                                       |
| Reviewed By                      | Review           | ved E | Зу                                    | Da   | te:       | Signature | of Surve      | yor:                                  |             |                  |           | Date: |                                       |
| State Agency                     | / PK/            | mr    | n                                     | 0    | 3/16/20   | 015       | 28            | 3035                                  |             |                  |           | 03/1  | 1/2015                                |
| Reviewed By                      |                  |       |                                       | Da   |           | Signature |               |                                       |             |                  |           | Date: |                                       |
| CMS RO                           |                  |       |                                       |      |           |           |               |                                       |             |                  |           |       |                                       |
| Followup to Survey Completed on: |                  |       |                                       |      | Chec      | k for anv | Uncorrected [ | Defici                                | encies. Was | a Summary of     | +         |       |                                       |
| 1/16/2015                        |                  |       |                                       |      |           |           |               |                                       |             | to the Facility? | YES       | NO    |                                       |

#### **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 /<br>Identification Number<br>245581 | (Y2) Multiple Construction<br>A. Building<br>B. Wing<br>01 - DINI | NG ADDITION 01                           | (Y3) Date of Revisit<br>2/26/2015 |
|--|---|--|-----------------------------------|
| Name of Facility   |   | Street Address, City, State, Zip Code    |                                   |
| FAIR OAKS LODGE  |   | 201 SHADY LANE DRIVE<br>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                    |
|--------------|----------------------|---|-----------|--------------------|-------------------------|---------------------|------------|-------------------------|
|              |                      | Correction  |           |                    | Correction              |                     |            | Correction              |
|              |                      | Completed   |           |                    | Completed               |                     |            | Completed               |
| ID Prefix    |                      | 02/16/2015  | ID Prefix |                    | -                       | ID Prefix           |            |                         |
| •            | NFPA 101             |   | Reg. #    |                    |                         | Reg. #              |            |                         |
| LSC          | K0052                |   | LSC _     |                    |                         |                     |            |                         |
|              |                      | Correction  |           |                    | Correction              |                     |            | Correction              |
|              |                      | Completed   |           |                    | Completed               |                     |            | Completed               |
| ID Prefix    |                      |   | ID Prefix |                    |                         | ID Prefix           |            |                         |
| Reg. #       |                      |   | Reg. #    |                    |                         | Reg. #              |            |                         |
| LSC          |                      |   | LSC       |                    |                         | LSC                 |            |                         |
|              |                      | Correction  |           |                    | Correction              |                     |            | Correction              |
|              |                      | Completed   |           |                    | Completed               |                     |            | Completed               |
| ID Prefix    |                      | _   | ID Prefix |                    |                         | ID Prefix           |            |                         |
| Reg. #       |                      |   | Reg. #    |                    |                         | Reg. #              |            |                         |
| LSC          |                      |   | LSC       |                    |                         | LSC                 |            |                         |
|              |                      | 0   |           |                    | o "                     |                     |            | 0                       |
|              |                      | Correction<br>Completed                                   |           |                    | Correction<br>Completed |                     |            | Correction<br>Completed |
| ID Prefix    |                      | Completed   | ID Prefix |                    | Completed               | ID Prefix           |            | Completed               |
| Reg. #       |                      |   | Reg. #    |                    |                         |                     |            |                         |
| LSC          |                      |   | LSC       |                    |                         | LSC                 |            |                         |
|              |                      | Correction  |           |                    | Correction              |                     |            | Correction              |
|              |                      | Completed   |           |                    | Completed               |                     |            | Completed               |
| ID Prefix    |                      |   | ID Prefix |                    |                         | ID Prefix           |            |                         |
| Reg. #       |                      |   | Reg. #    |                    |                         | Reg. #              |            |                         |
| LSC          |                      |   | LSC       |                    |                         | LSC                 |            |                         |
|              |                      |   |           |                    |                         |                     |            |                         |
| Reviewed By  | / Reviewed I         | Ву  | Date:     | Signature of Surve | yor:                    |                     | Date:      |                         |
| State Agency | y PS/mm              | 1   | 03/16/201 | 5 27               | 200                     |                     | 02/        | 26/2015                 |
| Reviewed By  | Reviewed I           | Ву  | Date:     | Signature of Surve | yor:                    |                     | Date:      |                         |
| CMS RO       |                      |   |           |                    |                         |                     |            |                         |
| Followup to  | Survey Completed on: |   |           | Check for any      | Uncorrected I           | Deficiencies. Was a | Summary of |                         |
| 2/6/2015     |                      | Uncorrected Deficiencies (CMS-2567) Sent to the Facility? |           |                    |                         |                     | NO         |                         |

#### State Form: Revisit Report

| (Y1)            | Provider / Supplier / CLIA /<br>Identification Number<br>00679 | <b>(Y2) Multiple Construction</b><br>A. Building<br>B. Wing | (Y3) Date of Revisit<br>3/11/2015        |  |
|-----------------|--|---|--|--|
| Name            | of Facility  |   | Street Address, City, State, Zip Code    |  |
| FAIR OAKS LODGE |  |   | 201 SHADY LANE DRIVE<br>WADENA, MN 56482 |  |

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item     | (Y5                      | ) Date                  | (Y4) Item | (Y5)                      | Date                    | (Y4)     | ltem          |                  | (Y5)      | Date                    |
|---------------|--------------------------|-------------------------|-----------|---------------------------|-------------------------|----------|---------------|------------------|-----------|-------------------------|
|               |                          | Correction              |           |                           | Correction              |          |               |                  |           | Correction              |
|               |                          | Completed               |           |                           | Completed               |          |               |                  |           | Completed               |
| ID Prefix     | 20302                    | 02/16/2015              | ID Pref   | ix <b>20565</b>           | 02/16/2015              |          | ID Prefix     | 20830            |           | 02/16/2015              |
| 0             | MN State Statute 144.650 | 3                       | -         | # MN Rule 4658.0405 Subp. | 3                       |          | 0             | MN Rule 4658.    | 0520 Subp | <b>b.</b> 1             |
| LSC           |                          | _                       | LS        | c                         | -                       |          | LSC           |                  |           | _                       |
|               |                          | Correction              |           |                           | Correction              |          |               |                  |           | Correction              |
|               |                          | Correction<br>Completed |           |                           | Correction<br>Completed |          |               |                  |           | Correction<br>Completed |
| ID Prefix     | 20840                    | 02/16/2015              | ID Pref   | ix <b>20900</b>           | 02/16/2015              |          | ID Prefix     | 21915            |           | 02/16/2015              |
| Reg. #        | MN Rule 4658.0520 Subp.  | 2 B                     | Reg.      | # MN Rule 4658.0525 Subp. | 3                       |          | Reg. #        | MN St. Statute   | 144.651 S | ubd. 2                  |
|               |                          | _                       |           | c                         |                         |          | •             |                  |           |                         |
|               |                          |                         |           |                           |                         |          |               |                  |           |                         |
|               |                          | Correction              |           |                           | Correction              |          |               |                  |           | Correction              |
| ID Prefix     |                          | Completed               |           | iv                        | Completed               |          | ID Prefix     |                  |           | Completed               |
|               |                          | _                       |           | ix                        | _                       |          |               |                  |           |                         |
| Reg. #        |                          | _                       | Reg.      |                           | -                       |          | Reg. #        |                  |           | _                       |
|               |                          | -                       |           | ·                         | _                       |          | 130           |                  |           | _                       |
|               |                          | Correction              |           |                           | Correction              |          |               |                  |           | Correction              |
|               |                          | Completed               |           |                           | Completed               |          |               |                  |           | Completed               |
| ID Prefix     |                          | •                       | ID Pref   | ix                        |                         |          | ID Prefix     |                  |           |                         |
| Reg. #        |                          |                         | Reg.      | #                         |                         |          | Reg. #        |                  |           |                         |
| LSC           |                          | -                       | LS        |                           | -                       |          | LSC           |                  |           | _                       |
|               |                          |                         |           |                           |                         | <u> </u> |               |                  |           |                         |
|               |                          | Correction              |           |                           | Correction              |          |               |                  |           | Correction              |
| ID Prefix     |                          | Completed               |           | iv                        | Completed               |          | ID Prefix     |                  |           | Completed               |
|               |                          | _                       |           | ix                        | _                       |          |               |                  |           |                         |
| Reg. #<br>LSC |                          |                         | Reg.      | 0                         |                         |          | Reg. #<br>LSC |                  |           |                         |
| L3C           |                          |                         | L3        | ·                         |                         |          | 130           |                  |           |                         |
|               |                          |                         |           |                           |                         |          |               |                  |           |                         |
| Reviewed By   | Reviewed                 | Ву                      | Date:     | Signature of Surve        | evor:                   | 1        |               |                  | Date:     |                         |
| State Agency  | , PK/m                   | m                       | 04/09/2   | -                         | 2803                    | 35       |               |                  |           | 1/2015                  |
| Reviewed By   |                          |                         | Date:     | Signature of Surve        | eyor:                   |          |               |                  | Date:     |                         |
| CMS RO        |                          |                         |           |                           |                         |          |               |                  |           |                         |
| Followup to   | Survey Completed on:     |                         |           | Check for any             | Uncorrected I           | Deficie  | ncies. Was    | a Summary of     | -         |                         |
| 1/16/2015     |                          |                         |           |                           |                         |          |               | to the Facility? | YES       | NO                      |
| STATE FORM    | 1: REVISIT REPORT (      | 5/99)                   |           | Page 1 of 1               |                         |          |               | Event ID:        | QMWJ12    |                         |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

|   |  | AND TRANSMITTAL<br>TE SURVEY AGENCY            | ID: QMWJ<br>Facility ID: 00679  |                               |   |  |  |  |
|---|--|--|---|-------------------------------|---|--|--|--|
| 1. MEDICARE/MEDICAID PROVIDER NO.           (L1)         245581           2.STATE VENDOR OR MEDICAID NO.         (L2)           719475700         (L2)  | <ol> <li>NAME AND ADDRESS OF FACILITY</li> <li>(L3) FAIR OAKS LODGE</li> <li>(L4) 201 SHADY LANE DRIVE</li> <li>(L5) WADENA, MN</li> </ol> |  |   | (L6) <b>56482</b>             | 4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other |  |  |  |
| <ol> <li>5. EFFECTIVE DATE CHANGE OF OWN<br/>(L9) 01/01/2004</li> </ol>   | ERSHIP   | 7. PROVIDER/SUF<br>01 Hospital                 | PPLIER CATEGORY<br>05 HHA   | 09 ESRD                       | <u>02</u> (L7)<br>13 PTIP 22 CLIA   | 8. Full Survey After Complaint   |  |  |
| <ul> <li>6. DATE OF SURVEY 01/16/</li> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited 1 TJC 2 AOA 3 Other</li> </ul>  | 2015 (L34)<br>(L10)  | 02 SNF/NF/Dual<br>03 SNF/NF/Distinct<br>04 SNF | 06 PRTF<br>07 X-Ray<br>08 OPT/SP  | 10 NF<br>11 ICF/III<br>12 RHC | 14 CORF<br>D 15 ASC<br>16 HOSPICE   | FISCAL YEAR ENDING DATE: (L35)<br>12/31  |  |  |
| 11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF         75         (L37)       (L38)         16. STATE SURVEY AGENCY REMARK | 75 (L18)<br>75 (L17)<br>19 SNF<br>(L39)<br>S (IF APPLICABLE S  | X B. Not in Com<br>Requireme<br>ICF<br>(L42)   | ce With<br>quirements<br>Based On:<br>ccceptable POC<br>pliance with Program<br>ents and/or Applied V<br>IID<br>(L43) |                               | And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):     | Following Requirements:        6. Scope of Services Limit        7. Medical Director        8. Patient Room Size        9. Beds/Room         (L12) |  |  |
| 17. SURVEYOR SIGNATURE  | ·  |  | 02/20/2015  | (L19)                         | 18. STATE SURVEY AGENCY APPROVAL     Date:       Mark Meath, Enforcement Specialist     02/26/2015  |  |  |  |
| 19. DETERMINATION OF ELIGIBILITY          1. Facility is Eligible to Part          2. Facility is not Eligible  |  | 20. COM  | D BY HCFA RE  |                               | 21. 1. Statement of Financia 2. Ownership/Control Ir 3. Both of the Above :   |  |  |  |
| 22. ORIGINAL DATE<br>OF PARTICIPATION<br>11/01/1991   | 23. LTC AGREEMI<br>BEGINNING   |  | 4. LTC AGREEME  |                               | 26. TERMINATION ACTION: <u>VOLUNTARY</u> 00     01-Merger, Closure     02-Dissatisfaction W/ Reimbursemen   | 05-Fail to Meet Health/Safety  |  |  |
| (L24)<br>25. LTC EXTENSION DATE:<br>(L27)   | (L41)<br>27. ALTERNATIVI<br>A. Suspension o<br>B. Rescind Sus  | of Admissions:                                 | (L25)<br>(L44)  |                               | 03-Risk of Involuntary Termination<br>04-Other Reason for Withdrawal  | OTHER<br>07-Provider Status Change<br>00-Active  |  |  |
| 28. TERMINATION DATE:   | 29   | . INTERMEDIARY/C                               | (L45)<br>ARRIER NO.   |                               | 30. REMARKS   |  |  |  |
|   | (L28)  | 03001  | Posted 03/03/2015 Co.   |                               |   |  |  |  |
| 31. RO RECEIPT OF CMS-1539  | 32<br>(L32)  | . DETERMINATION (                              | DF APPROVAL DAT   | Е<br>(L33)                    | DETERMINATION APPROV  |  |  |  |
|   | ()   |  |   | (200)                         | DETERMINATION APPROV  |  |  |  |



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered February 6, 2015

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

RE: Project Number S5581024

Dear Mr. Blanchard:

On January 16, 2015, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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:

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

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

## <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

## <u>Informal Dispute Resolution</u> - 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:

Pam Kerssen, RN, APM Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: pam.kerssen@state.mn.us

Telephone: (218) 308-2129 Fax: (218) 308-2122

## **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 February 25, 2015, 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 February 25, 2015 the following remedy will be imposed:

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

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.
Fair Oaks Lodge February 6, 2015 Page 4

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

#### 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 April 16, 2015 (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.

Fair Oaks Lodge February 6, 2015 Page 5

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 July 16, 2015 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0525 Fair Oaks Lodge February 6, 2015 Page 6

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

Sincerely,

# Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

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| DEPART                   | MENT OF HEALTH   | AND HUMAN SERVICES   |                     |     | ·   |                               | APPROVED                   |
|--------------------------|--|--|---------------------|-----|---|-------------------------------|----------------------------|
| CENTER                   | RS FOR MEDICARE  | & MEDICAID SERVICES  | -                   |     | 0   | MB NO                         | . 0938-0391                |
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|                          |  | 245581   | B. WING             |     |   | 01/                           | /16/2015                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                     | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | -                             |                            |
| FAIR OA                  | KS LODGE   |  |                     |     | 01 SHADY LANE DRIVE<br>/ADENA, MN 56482   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT  | ſS   | F 0                 | 00  |   |                               |                            |
|                          | as your allegation o<br>Department's accer   | of correction (POC) will serve<br>f compliance upon the<br>ptance. Your signature at the<br>age of the CMS-2567 form will<br>ion of compliance.  |                     |     |   |                               |                            |
| F 279<br>SS=D            | on-site revisit of you validate that substa  |  | F 2                 | :79 |   |                               | 2/16/15                    |
| 00-0                     | A facility must use t  | he results of the assessment<br>and revise the resident's  |                     |     |   |                               |                            |
|                          | plan for each reside<br>objectives and time<br>medical, nursing, and   | evelop a comprehensive care<br>ent that includes measurable<br>tables to meet a resident's<br>nd mental and psychosocial<br>tified in the comprehensive  |                     |     |   |                               |                            |
|                          | to be furnished to a<br>highest practicable<br>psychosocial well-b<br>§483.25; and any s<br>be required under §<br>due to the resident | tain or maintain the resident's<br>physical, mental, and<br>eing as required under<br>ervices that would otherwise<br>483.25 but are not provided<br>s exercise of rights under<br>the right to refuse treatment<br>). |                     |     |   |                               |                            |
|                          | This REQUIREMEN  | NT is not met as evidenced   |                     |     |   |                               |                            |
|                          | Y DIRECTOR'S OR PROVID   | ER/SUPPLIER REPRESENTATIVE'S SIGN  | NATURE              |     | TITLE   |                               | (X6) DATE<br>02/16/2015    |

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.

PRINTED: 02/20/2015

|   |   | AND HUMAN SERVICES  |                    |     |  | FORM   | 02/20/2015<br>APPROVED<br>0938-0391 |
|---|---|---|--------------------|-----|--|--|-------------------------------------|
| STATEMENT OF DEFICIENC<br>AND PLAN OF CORRECTIO   | CIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     |  | (X3) DATE  | E SURVEY<br>PLETED                  |
|   |   | 245581  | B. WING            |     |  | 01/1   | 16/2015                             |
| NAME OF PROVIDER OR   | SUPPLIER  |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |  |                                     |
| FAIR OAKS LODGE   |   |   |                    |     | 01 SHADY LANE DRIVE<br>/ADENA, MN 56482  |  |                                     |
| PREFIX (EACH D  | EFICIENC  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | BE   | (X5)<br>COMPLETION<br>DATE          |
| facility faile<br>plan that in<br>antidepres<br>needed) or<br>medication<br>for unnece<br>Findings in<br>R31 was a<br>Diagnosis<br>Report incl<br>other perso<br>Report also<br>7.5 mg (mi<br>appetite, d<br>well as Ativ<br>anxiety or s<br>The Minim<br>did not ider<br>mental stat<br>(prospectiv<br>28, 2014, i<br>moderately<br>Review of<br>(MAR) for<br>2014, and<br>Ativan twic<br>four times<br>(through 1/<br>charting in<br>behaviors of<br>The facility | interview<br>d to dev<br>icluded t<br>sant med<br>der for A<br>) for 1 c<br>ssary me<br>iclude:<br>dmitted<br>identified<br>uded an<br>onality di<br>o identified<br>o identified<br>van 0.5 n<br>sleep.<br>um Data<br>ntify a Bl<br>tus) for c<br>ve payme<br>dentified<br>v impaire<br>the medi<br>October,<br>January<br>e in Octo<br>in Decer<br>(14/15).<br>the nurs<br>occurred | v and document review, the<br>elop a comprehensive care<br>he daily use of Remeron (an<br>dication) and a PRN (as<br>tivan (an antianxiety<br>of 5 residents (R31) reviewed | F 2                | 279 | Resident #31 suffered no ill Effects<br>not having Remeron and Ativan on h<br>care plan. Resident # 31 has had ca<br>plan reviewed and revised to reflect<br>use of Remeron and Ativan.<br>All residents on antianxiety and<br>antidepressants have the potential to<br>affected by the practice.<br>SW, MDS Coordinator and Nurse<br>managers will receive education on<br>completing care plans that include<br>incorporating these classes of<br>medications in their care plans.<br>SW, and NM will update all care plan<br>assure the class of medication in inc<br>in current care plans and MDS/SW of<br>develop care plans for all new<br>admissions.<br>DON/Designee will assure process i<br>completed and will audit care plans<br>weekly x 3 moths to assure system i<br>intact.<br>Findings from audits will be reviewed<br>QAA x 3 months to assure trends or<br>negative findings of audits are correc<br>Corrective Action | his<br>are<br>the<br>o be<br>ns to<br>cluded<br>will<br>is<br>is<br>d at |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |  |  |   | FORM                          | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245581  | B. WING                                |  |   | 01/ <sup>-</sup>              | 16/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |  |  | TREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FAIR OA                  | KS LODGE   |   |  |  | 01 SHADY LANE DRIVE<br>/ADENA, MN 56482   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG                    |  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI/<br>DEFICIENCY)   |                               | (X5)<br>COMPLETION<br>DATE          |
| F 279<br>F 282<br>SS=E   | behaviors related to<br>poor impulse contro-<br>interventions of mor-<br>needs, monitor ever<br>observed behavior a<br>behavior log, monitor<br>the situation and all<br>express himself, pro-<br>good behavior and a<br>aspects of compliar<br>agitated intervene b<br>guide away form so<br>calmly in conversati<br>and Ativan were not<br>During interview wit<br>1/14/15, at 2:30 p.m<br>medications were n<br>and that she would<br>483.20(k)(3)(ii) SEF<br>PERSONS/PER CA<br>The services provide<br>must be provided by<br>accordance with ea<br>care.<br>This REQUIREMEN<br>by:<br>Based on observat<br>review, the facility fa<br>of care for 2 of 2 res<br>at risk for pressure<br>(R102) who required | <ul> <li>ineffective coping skills and bl. Non pharmacological nitor and anticipate resident's ry shift and document and attempted interventions in or resident's understanding of ow time for the resident to ovide positive feedback for emphasize the positive nce, when he becomes before agitation escalates, burce of distress, engage ion. The use of the Remeron t addressed on the care plan.</li> <li>th the director of nursing on n. she verified that the tot addressed on the care plan expect them to be.</li> <li>RVICES BY QUALIFIED ARE PLAN</li> <li>led or arranged by the facility y qualified persons in ch resident's written plan of</li> <li>NT is not met as evidenced ion, interview, and document ailed to follow the written plan sidents (R49, R102) reviewed ulcers, for 1 of 2 resident d assistance with toileting, ents (R51) reviewed for</li> </ul> | F 2                                    |  | No negative affects to resident @#4<br>#51 and #102 have been noted due to<br>deficient practice. Resident #49, #51<br>#102 have been assessed by an RN<br>care plan reviewed.<br>Any resident requiring assistance wit<br>ADL's and assistive devices may be<br>affected by this practice. | l9,<br>to<br>⊨and<br>I and    | 2/16/15                             |

Facility ID: 00679

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|                          | OF DEFICIENCIES   | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA  | (X2) MUL           |  | <u>D. 0938-039</u><br>ATE SURVEY |
|--------------------------|---|---|--------------------|--|----------------------------------|
|                          | OF CORRECTION   | IDENTIFICATION NUMBER:  |                    |  | OMPLETED                         |
|                          |   | 245581  | B. WING            | NG 0   | 1/16/2015                        |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE  |                                  |
| FAIR OA                  | KS LODGE  |   |                    | 201 SHADY LANE DRIVE<br>WADENA, MN 56482   |                                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | EFIX (EACH CORRECTIVE ACTION SHOULD BE   | (X5)<br>COMPLETIC<br>DATE        |
| F 282                    | Continued From pa   | ge 3  | F 2                | F 282  |                                  |
|                          | 12/1/14, indicated F<br>peripheral vascular<br>cerebrovascular acc<br>hemiplegia. The M<br>cognitively intact, re<br>of 2 staff to physica<br>transfers, dressing,<br>identified at risk for<br>and had 2 unstagea<br>injuries in evolution<br>subcutaneous tissu<br>recommended R49<br>device to chair and<br>R49's current care<br>staff to off load (reli<br>and recliner, wear a<br>heel guards on in b<br>inspection, update p<br>turn and reposition<br>right AFO (foot drop<br>when in wheel chain<br>R49's Nurse Aid Ca<br>directed staff to use<br>while in recliner and<br>pillow.<br>During observation<br>at 7:05 a.m. nursing<br>were getting R49 di<br>his recliner. After F<br>proceeded to assist<br>his wheelchair. R49<br>tennis shoes on bot | cident (stroke), and<br>DS also indicated R49 was<br>equired extensive assistance<br>Ily help him with bed mobility,<br>and toileting. R49 was<br>developing pressure ulcers,<br>able suspected deep tissue<br>(a pressure related injury to<br>es under intact skin) and<br>have a pressure relieving<br>bed.<br>plan dated 11/24/14, instructed<br>eve pressure) heels in bed<br>a left heel derma saver, have<br>ed and recliner, weekly skin<br>obysician on skin changes,<br>every 4 hours, and to wear<br>o brace) with transfers and |                    | <ul> <li>Nursing staff have been educated on following resident's plan of care, including following their group assignments which they are to carry with them versus staff statement that it is a "free for all". Group assignments reveal toileting, repositionin and assistive devices residents require.</li> <li>LN have received education on following plan of care for residents with pressure and non-pressure related skin conditions.</li> <li>LN will update care plans and group assignment sheets PRN, regarding residents cares.</li> <li>DON/Designee will complete observational audits weekly, on various shifts x 3 months to assure NAR's are carrying their group sheets and are following interventions listed on the care sheet.</li> <li>DON/Designee will complete observational audits on skin documentation weekly on various shifts x 3 months to assure nurse are following care plan on any resident with care plan related to pressure and non-pressure related skin conditions.</li> <li>Findings from audits will be reviewed at QAA x 3 months to assure trends or negative findings of audits are corrected. Corrective Action is to be completed by 2/25/15.</li> </ul> | g<br>                            |

|                          |  | AND HUMAN SERVICES  |                     |   |                         | FORM             | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | IPLE CONSTRUCTION   | 0                       | (X3) DATE        | E SURVEY<br>PLETED                  |
|                          |  | 245581  | B. WING             |   |                         | 01/ <sup>-</sup> | 16/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZI   | , CODE                  |                  |                                     |
| FAIR OA                  | KS LODGE   |   |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |                         |                  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD<br>HE APPROPF | BE               | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | Continued From pa  | ge 4  | F 28                | 32  |                         |                  |                                     |
|                          | room, and his feet w<br>rest of the recliner a<br>black tennis shoes<br>resident continued f<br>GNP entered his ro<br>black tennis shoes<br>stated R49 had a bl<br>x 1 cm and "right fo<br>During observation<br>was sitting in his rea<br>on the foot rest of th<br>on, and the derma s<br>bed and not on his<br>R49's Tissue Tolera<br>11/25/14, indicated<br>pressure on R49's I<br>was to have his left<br>savers on.<br>During interview on<br>stated R49 had dee<br>wearing his shoes i<br>R49 liked to sit in hi<br>instructed to ensure<br>should not be weari<br>wearing gel boots.<br>During interview on<br>stated R49 was to b | on 1/15/15, at 3:30 p.m. R49<br>cliner, had his feet elevated up<br>he recliner. R49 had no shoes<br>saver boots were laying on his<br>feet.<br>ance Collection Sheet dated<br>skin issues related to<br>left heel, and indicated R49<br>heel off loaded with derma<br>1/14/15, at 8:55 a.m. GNP<br>ep tissue injuries caused by<br>n the recliner. GNP stated<br>is recliner, and staff was<br>e R49 had his heels off loaded,<br>ing shoes, and should be<br>1/14/15, at 2:00 p.m. NA-E<br>be wearing derma savers on |                     |   |                         |                  |                                     |
|                          | over the foot rest of<br>NA-E stated this is<br>remember to do it."  | re his shoes off with his heels<br>f recliner and off load heels.<br>completed for R49, "When I<br>nterview on 1/15/15, at 10:36  |                     |   |                         |                  |                                     |

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|                          |  | AND HUMAN SERVICES   |                    |     |   | FORM                          | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245581   | B. WING            |     |   | 01/ <sup>.</sup>              | 16/2015                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FAIR OA                  | KS LODGE   |  |                    |     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | a.m. NA-E confirme<br>AFO brace to his rig<br>in his wheelchair. F<br>wearing the AFO br<br>where the brace wa<br>During interview on<br>physical therapist a<br>was to wear a AFO<br>stated, "I am not su<br>PTA-A stated there<br>the AFO brace, so r<br>it on.<br>During interview on<br>registered nurse (R<br>shoes should be off<br>should have gel boo<br>the AFO brace.<br>During interview on<br>of nursing (DON) co<br>for R49 instructed s<br>brace to his right fo<br>the heel and while i<br>have derma safer g<br>R102 was not assis<br>according to the pla<br>R102's quarterly MI<br>the resident had dia<br>healing hip fracture<br>amputee, congestiv<br>chronic kidney dise<br>the resident had no<br>required extensive a<br>daily living except e | ed R49 was to be wearing a<br>ght foot for transfers and while<br>R49 stated R49 had not been<br>race and she was not aware<br>as at.<br>1/15/15, at 10:45 a.m.<br>ssistant (PTA)-A stated R49<br>brace to his right foot and<br>ire if he has been wearing it."<br>was an order for R49 to wear<br>nursing staff should be putting<br>1/15/15 at 11:20 a.m.<br>N)-B confirmed that R49's<br>f when he is in the recliner,<br>ots on, and should be wearing<br>1/15/15, at 3:15 p.m. director<br>onfirmed the current care plan<br>staff R49 was to have a AFO<br>ot during transfer to protect<br>n his wheelchair, and was to<br>gel boots when in the recliner.<br>Sted with repositioning<br>an of care.<br>DS dated 12/16/14, identified<br>agnoses including depression,<br>, right arm below the elbow<br>ve heart failure, fatigue, and<br>ase. The MDS also identified<br>cognitive impairment and<br>assistance for all areas of | F 2                | 282 |   |                               |                                     |

|                          |   | AND HUMAN SERVICES  |                     |  | FORM      | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245581  | B. WING             |  | 01/       | 16/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | •         |                                     |
| FAIR OA                  | KS LODGE  |   |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE      | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | 12/10/14, identified<br>in the wheelchair ar<br>without redness to l<br>R102's current care<br>the resident had a r<br>related to decrease<br>instructed to turn ar<br>hours and as neede<br>benefits to the resid<br>with changing incor<br>not to remain in we<br>During continuous of<br>1/14/2015, the follo<br>7:11 a.m. R102 was<br>wheel chair.<br>7:49 a.m. R102 ref<br>the dining room.<br>8:17 a.m. R102 was<br>room and remained<br>being repositioned.<br>8:54 a.m. R102 ref<br>the wheelchair and<br>8:57 a.m. R102 was<br>room for an activity<br>wheelchair.<br>9:09 a.m. R102 ref<br>wheelchair.<br>10:25 a.m. R102 ref<br>wheelchair and had<br>10:48 a.m. NA-D pt<br>by the nurses statio<br>R102 had not been<br>During interview on<br>stated the nursing a | R102 was able to be seated<br>and lay in bed for 2 hours<br>bony prominence's.<br>A plan dated 12/8/14, identified<br>risk for skin break down<br>and mobility, and staff was<br>and reposition R102 every 2<br>ed, and to explain risks and<br>dent of allowing staff to assist<br>attinent clothing and brief, and<br>t clothing.<br>A posservation of R102 on<br>wing was observed:<br>a seated in the hallway in a<br>attined in his wheelchair in<br>a brought to the television<br>d in his wheelchair without<br>and not been repositioned.<br>and remained in the<br>and provided R102 a snack.<br>repositioned since 7:11 a.m.<br>1/14/15, at 10:32 a.m. NA-E<br>assistants did not have<br>e for specific residents, and | F 282               |  |           |                                     |

|                          | -  | AND HUMAN SERVICES   |                     |  | FORM     | : 02/20/2015<br>APPROVED<br>. 0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | LE CONSTRUCTION  | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |  | 245581   | B. WING             |  | 01/      | 16/2015                                 |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |   |
| FAIR OA                  | KS LODGE   |  |                     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482  |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE              |
| F 282                    | Continued From pa  | ige 7  | F 282               |  |          |   |
|                          | 10:42 a.m. NA-E st<br>cares on a time sch<br>R102 was on a rep<br>stated R102 was of | interview on 01/14/2015, at<br>ated staff did not provide<br>nedule, and she was not aware<br>ositioning schedule. NA-E<br>ften in his wheel chair all<br>ted she was not aware if R102<br>ned that morning. |                     |  |          |   |
|                          | stated R102's curre required extensive   | 1/14/2015, 11:13 a.m. RN-B<br>ent care plan indicated R102<br>assistance with repositioning,<br>to reposition the resident   |                     |  |          |   |
|                          | RN-B and NA-F we toileting. NA-B and and transfer to the                             | on 1/14/2015, at 11:22 a.m.<br>ere asked to assist R102 with<br>I NA-F assisted R102 to stand<br>toilet. R102's skin on his<br>to but wrinkled and creased.  |                     |  |          |   |
|                          | RN-B stated R102<br>repositioned every<br>assistant care shee<br>used to provide car | a 1/16/2015, at 10:11 a.m.<br>was assessed to be<br>2 hrs, however, the nursing<br>et (identified as what the NAs<br>res to residents) did not<br>a and reposition every two<br>tin breakdown.               |                     |  |          |   |
|                          | DON stated R102 s<br>every 2 hours, and  | a 1/16/2015, at 11:31 a.m. the<br>should have been repositioned<br>stated the resident should not<br>nours without repositioning.  |                     |  |          |   |
|                          | toileting according t<br>R102's diagnoses i<br>right arm below the                   | ided timely assistance with<br>to the plan of care.<br>ncluded healing hip fracture,<br>elbow amputee, and chronic<br>02's quarterly MDS dated   |                     |  |          |   |

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|                          |   | 245581   | B. WING             |   | 01/       | 16/2015                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FAIR OA                  | KS LODGE  |  |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | 12/16/14, identified<br>The quarterly MDS<br>extensive assistance<br>care plan dated to be<br>he required toileting<br>needed. R102 was<br>already incontinent.<br>During intermittent of<br>from 7:11 a.m. and<br>observation from 93<br>R102 had not been<br>observation on 1/12<br>assisted to toilet. R<br>stool, with a small a<br>stool on his bottom<br>During interview on<br>indicated the nursin<br>assignments to care<br>stated it was, "Just<br>During a second int<br>a.m. NA-E identified<br>a time schedule. NJ<br>would tell staff if he<br>bathroom. NA-E ve<br>R102 to be in his w<br>verified that she hat<br>toilet so far that mo<br>During an interview<br>NA-D indicated R10<br>to go to the bathroot<br>believed R102 was<br>verified that she hat<br>morning. | R102 was cognitively intact.<br>also identified R102 required<br>be for toileting. R102's current<br>be revised 12/8/14, identified<br>g every two hours and as<br>to be checked and changed if<br>observations on 1/14/2015,<br>9:09 a.m. and continuous<br>13 a.m. through 10:48 a.m.<br>assisted with toileting. During<br>4/15, at 11:22 a.m. R102 was<br>102 had been incontinent of<br>amount of soft non formed<br>and in the incontinence brief.<br>1/14/15, at 10:32 a.m. NA-E<br>ng assistants did not have<br>e for specific residents. NA-E<br>free for all."<br>terview on 1/14/15, at 10:42<br>d staff do not provide cares on<br>A-E further identified R102<br>needed to go to the<br>rified it was not unusual for<br>heelchair all morning. NA-E<br>d not assisted R102 to the | F 282               |   |           |                                     |

|                          |  | AND HUMAN SERVICES   |                     |   | FORM      | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245581   | B. WING             |   | 01/       | 16/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FAIR OA                  | KS LODGE   |  |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | indicated R102 did<br>plan. NA-F identifie<br>and bladder, and at<br>go to the bathroom<br>NA-F indicated R10<br>the bathroom in the<br>had not toileted R10<br>During an interview<br>RN-B verified R102<br>every 2 hrs and it w<br>it was not on the nu<br>"and that is why it w<br>nursing assistant ca<br>reflect the need for<br>During an interview<br>DON verified she w<br>be performed as did<br>assessments and ca<br>R51's skin condition<br>monitored or docum<br>plan.<br>The care plan dated<br>observe skin with ro<br>to nurse any chang<br>bruising as it is a po<br>therapy. The care plan<br>documentation of re<br>The quarterly MDS<br>was cognitively inta<br>all activities of daily<br>R51 had diagnoses | not have a scheduled toileting<br>d R102 was continent of bowel<br>t times knew if he needed to<br>or if he had been incontinent.<br>D2 would usually be taken to<br>e morning. NA-F verified she<br>02.<br>on 1/16/2015, at 10:11 a.m.<br>2 was assessed to be toileted<br>vas on the care plan. However,<br>ursing assistant care sheet,<br>vas missed." RN-B verified the<br>are sheets had been revised to<br>toileting every two hours.<br>on 1/16/15, at 11:31 a.m. the<br>vould expect residents care to<br>rected by the resident<br>care plan.<br>n was not assessed,<br>nented according to the care<br>d, 3/17/10, directed staff to<br>outine daily care, and to report<br>es noted, and to observe for<br>otential side effect of aspirin<br>plan also directed staff to<br>kin inspection with<br>esults.<br>dated 12/29/14, indicated R51<br>tot and required assistance for<br>f living. The MDS indicated<br>s which included degenerative<br>na, Parkinson's, diabetes | F 282               |   |           |                                     |

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| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                               |                     |    | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245581  | B. WING _           |    |  | 01/                           | 16/2015                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                     |    | REET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FAIR OA                  | KS LODGE   |   |                     |    | 1 SHADY LANE DRIVE<br>ADENA, MN 56482  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | <  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | Continued From pa  | ige 10  | F 28                | 82 |  |                               |                                     |
|                          | was seated in a wh<br>Observed one large<br>approximately 3 x 3<br>forearm, also observed<br>on resident's left for<br>on the right forearm<br>ago when her arm<br>bed. R51 stated th<br>hand also happene<br>caused when staff<br>grab bar next to the<br>her shirt to assist h<br>by accident get her<br>reported that she d<br>bruises easily. R51<br>about the bruises, t<br>had seen the bruises, t<br>had seen the bruise<br>dressed and undrear<br>During medical rect<br>was evident to indic<br>right and left forear<br>Skin assessment d<br>was at risk for skin<br>mobility, DM, edem<br>and bladder inconti<br>directed licensed st<br>assessments.<br>During interview on<br>confirmed she assis<br>including dressing o<br>R51 has real thin st<br>careful when movin | ord review, no documentation cate R51 had bruises on the                            |                     |    |  |                               |                                     |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |   | FORM                          | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |   | 245581  | B. WING            |     |   | 01/ <sup>.</sup>              | 16/2015                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | •                             |                                     |
| FAIR OA                  | KS LODGE  |   |                    |     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482   |                               |                                     |
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| F 282                    | had black and blue<br>hands. NA-B report<br>those bruises on Ri<br>asked if NA-B had in<br>nurses, she stated,<br>always had those b<br>she came here to th<br>During interview on<br>reported R51 bruise<br>confirm if R51 curre<br>reviewing the medic<br>she was the nurse f<br>stated staff would n<br>documenting bruise<br>resident's bath days<br>progress note docu<br>indicated no concert<br>time. LPN-A stated<br>inspection would hat<br>bath day) and confi<br>assessment docum<br>record related to sk<br>no staff had reporte<br>hands or arms. LP<br>with R51 consistent<br>During interview on<br>DON stated staff ar<br>bruising during daily<br>nurses right away s<br>monitor the bruise i<br>resolved. The DON<br>to follow the care pl<br>documenting result<br>Review of the facilit | bruises on both arms and<br>ted the nurses all know about<br>51's arms and hands. When<br>reported the bruises to the<br>no because the resident has<br>ruises on her skin ever since<br>his facility.<br>1/14/15, at 9:59 a.m. LPN-A<br>es very easily, but could not<br>ently had any bruises without<br>cal record. LPN-A confirmed<br>for R51 on 1/14/15. LPN-A<br>honitor bruises by<br>es in the progress notes on the<br>s. LPN-A reviewed R51's<br>d LPN-A reported the last<br>mented was on 1/2/15, and<br>rns to body surface at that<br>I R51's last weekly skin<br>ave been on 1/9/15 (R51's<br>rmed that the weekly skin<br>entation was missing in the<br>in condition. LPN-A confirmed<br>ed R51 having any bruising to<br>N-A stated she does not work<br>tly, and works all three floors.<br>1/14/15, at 12:47 p.m. the<br>e expected to observe for<br>y cares and report bruises to<br>o the nurse can assess and<br>n the progress notes until<br>A confirmed staff are expected<br>an which included<br>s of weekly skin inspections. | F 2                | 282 |   |                               |                                     |

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|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                               |                     | IPLE CONSTRUCTION   | (X3) DATE SUI<br>COMPLET                               |                         |
|--------------------------|---|---|---------------------|---|--|-------------------------|
|                          |   | 245581  | B. WING _           |   | 01/16/2  | 015                     |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |  | .015                    |
| FAIR OA                  | KS LODGE  |   |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | OULD BE COI  | (X5)<br>MPLETIO<br>DATE |
| F 282                    | indicated the care p<br>resident's medical,<br>psychosocial needs   | plans are designed to meet the<br>nursing, mental and<br>s, as identified in the    | F 28                | 32  |  |                         |
| F 309<br>SS=G            |   |   | F 30                | 09  | 2/1  | 6/15                    |
|                          | Each resident must receive and the facility must<br>provide the necessary care and services to attain<br>or maintain the highest practicable physical,<br>mental, and psychosocial well-being, in<br>accordance with the comprehensive assessment<br>and plan of care.  |   |                     |   |  |                         |
|                          | This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation, interview and document<br>review, the facility failed to comprehensively<br>assess pain and implement interventions to<br>relieve moderate to severe pain following a<br>surgical procedure to the lower back for 1 of 1<br>resident (R83) reviewed for pain, and failed to<br>monitor skin condition for 1 of 1 resident (R51)<br>reviewed with multiple bruises. This deficient<br>practice caused actual harm to R83. |   |                     | Resident #83 has been assess<br>physician and has had his care<br>updated and revised. The Medi<br>Director is aware of the residen<br>history and has been contacted<br>the primary care physician's pa<br>LN completed pain assessmen<br>resident #83, reviewed all<br>non-pharmacological and<br>pharmacological interventions a   | plan<br>cal<br>t's pain<br>as she is<br>rtner.<br>t on |                         |
|                          | Findings include;<br>R83's admission Minimum Data Set (MDS) dated<br>10/31/14, identified R83 had diagnoses which<br>included arthritis, other specific rehabilitation<br>procedure, malaise and fatigue, and difficulty<br>walking. The MDS identified R83 had severe<br>cognitive impairment and required extensive<br>assistance for activities of daily living (ADLs).<br>Further, the MDS identified R83 had occasional,<br>moderate pain, received scheduled pain                           |   |                     | <ul> <li>them to be appropriate.</li> <li>Any patient who has pain concerned be affected by this deficient prace of the proper non-pharmacological and pharmacological interventions to implemented.</li> <li>All residents plan of care has be reviewed and updated regarding insuring proper pharmacological care pharmacological</li></ul> | ctice.<br>ssessed for<br>d<br>o be<br>een<br>g pain,   |                         |

Facility ID: 00679

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| CENTEI<br>STATEMENT<br>AND PLAN C<br>NAME OF<br>FAIR OA<br>(X4) ID<br>PREFIX | RS FOR MEDICARE   | AND HUMAN SERVICES   | A. BUILI<br>B. WING | DING | E CONSTRUCTION (X3) D<br>C | D: 02/20/2015<br>M APPROVED<br>O. 0938-0391<br>ATE SURVEY<br>DMPLETED<br>1/16/2015 |
|--|---|--|---------------------|------|----------------------------|--|
| TAG<br>F 309   | Continued From par<br>medications, as neu-<br>and non-pharmaco-<br>management.<br>The Care Area Ass<br>indicated the goal w<br>slow/minimize decli-<br>of functioning. The<br>decline and physical<br>contributing/limiting<br>The Pain Data Coll-<br>dated 10/31/14, ide<br>pain, but has noted<br>cares and activity, u<br>goal, and irritability<br>The MDS dated 11/<br>cognitive impairment<br>identified R83 had wand<br>and constant, seve<br>that R83 had felt tir<br>every day. The MD<br>scheduled pain me<br>the use of any PRN<br>identified R83 had wand<br>interventions for par<br>R83's pain at a 10 of<br>worst pain).<br>R83 was admitted the<br>According to the re<br>to the facility on 12/<br>discitis of the lumba<br>R83 was readmitted<br>medications ordere<br>-Fentanyl (narcotic<br>severe pain) patch<br>72 hours<br>-Tylenol Extra Strey<br>mouth as needed for | ge 13<br>eded pain (PRN) medications<br>logical interventions for pain<br>essment (CAA) dated 11/4/14,<br>vas for improvement,<br>ne and maintain current level<br>CAA identified a mood<br>al limitations as<br>affect.<br>ection and Assessment form<br>entified R83 did not verbalize<br>grimacing and frowning with<br>unable to determine R83's pain<br>and change in mood noted.<br>/21/14, identified moderate<br>nt with no change. MDS<br>worsening mild depression<br>re pain. The MDS identified<br>ed or had little energy almost<br>S identified R83 was on<br>dications, and did not identify<br>I pain medications. MDS<br>non-pharmacological<br>in management and rated<br>on a scale of 1-10 (10 being<br>to the hospital on 12/17/14.<br>cord R83 had been readmitted<br>/23/14, with a diagnosis of<br>ar region.<br>d with the following pain<br>d:<br>pain medication to treat<br>25 mcg transdermally every<br>mgth tablet, 500 mg, 1 tablet by<br>pur times daily (QID) for pain<br>ngth tablet, 500 mg, 2 tablets | F                   | 309  | DEFICIENCY)                | ed<br>s<br>ed  |

Facility ID: 00679

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| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   |                     | LE CONSTRUCTION  | (X3) DATE  | 0938-039                  |
|--------------------------|---|---|---------------------|--|--|---------------------------|
| ND PLAN (                | OF CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING         | à  | COM  | PLETED                    |
|                          |   | 245581  | B. WING             |  | <b>01</b> /1   | 6/2015                    |
| NAME OF                  | PROVIDER OR SUPPLIER  |   | :                   | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |                           |
| FAIR OA                  | KS LODGE  |   |                     |  |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | ) BE   | (X5)<br>COMPLETIC<br>DATE |
| F 309                    | narcotic to treat mo<br>since 10/24/14<br>-Lidoderm Patch d<br>R83's readmission,<br>identified moderate<br>moderate depression<br>The MDS identified<br>The Admit/Readmit<br>12/23/14, identified<br>region and R83 ind<br>indicated on assession<br>pain, activity makes<br>it better, the pain and<br>he wanted to die. T<br>R83 would not cont<br>ADLs.<br>Physical therapy (P<br>R83 from 12/24/14<br>discharge summary<br>R83 was significant<br>barely able to comp<br>(AROM) in bed with<br>Occupational thera<br>for 12/24/14 to 1/22<br>of after 4 weeks of<br>maximum level of f<br>restrictive environm<br>identified that R83<br>comb his hair even<br>perform ADLs witho<br>throughout treatmet<br>therapy notes that I<br>and pain. R83 was<br>1/2/15, and include<br>wished he could ge | age 14<br>ohen and hydrocodone -<br>iderate to severe pain) on hold<br>iscontinued 12/23/14<br>5 day MDS dated 12/30/14,<br>cognitive impairment,<br>on and constant, severe pain.<br>R83's pain to be 10/10.<br>Pain Assessment dated<br>R83 had pain to the lumbar<br>icated pain was severe. R83<br>sment that he had stabbing<br>it worse, laying down makes<br>wakens him and R83 voiced<br>he assessment identified that<br>ribute to performance of his<br>T) services were provided for<br>to 1/2/15, for back pain. PT's<br>y from 1/2/15, identified that<br>thy limited by pain, and was<br>oblete active range of motion<br>nout excruciating pain.<br>py (OT) services were ordered<br>k/15. The OT identified a goal<br>OT, R83 would regain<br>unction to discharge to least<br>thent. The OT evaluation<br>was unable to wash his face or<br>with set-up and unable to<br>out extensive assistance<br>nt due to pain. OT identified in<br>R83 was limited by weakness<br>discontinued from OT on<br>d R83's statement of he<br>t out of here because anything<br>is wrong, and doesn't work for | F 309               | <ul> <li>Staff is to received education on provide transferring of patients using a gain and to report any pressure, or non-pressure related skin condition LN. The LN will contact the NM to proper interventions for skin care.</li> <li>DON/Designee will complete observational audits on various sh staff transfers weekly x 3 months to assure proper transfer with gait be used (unless care planned for lift). DON/Designee will complete observational skin audits on variou weekly x 3 months to observe for non-pressure related skin condition assure proper skin interventions ta place.</li> <li>Findings from audits will be review QAA x 3 months to assure trends on negative findings of audits are corr Corrective Action is to be complete 2/25/15.</li> </ul> | t belt<br>n to the<br>look at<br>fts of<br>o<br>lt is<br>s shifts<br>ns, to<br>ke<br>ed at<br>or<br>ected. |                           |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     |   | FORM      | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|---------------------|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | PLE CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245581   | B. WING             |   | 01/*      | 16/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | •         |                                     |
| FAIR OA                  | KS LODGE  |  |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | of osteoarthrosis ur<br>pelvic region and the<br>rehabilitation process<br>fatigue and difficulty<br>included back brack<br>ADLs and update M<br>care plan goal idem<br>relieved in 1 hour of<br>interventions includ<br>signs of pain and di<br>restlessness, winch<br>assessment per pro-<br>medication as orde<br>effectiveness. Report<br>to aid in comfort as<br>anticipate all pain n<br>language and facial<br>identified to observer<br>medications and up<br>and to assess for changed<br>and the spent in b<br>develop a plan of changed<br>and the spe | ispecified general location<br>igh, other specified<br>dure other, other malaise and<br>y walking. ADL interventions<br>e, provide assistance with<br>1D/family with changes. Pain<br>tified R83's pain will be<br>f intervention. Pain<br>ed: observe for and report<br>scomfort, verbal complaints,<br>ng, moaning, guarding. Pain<br>otocol and prn. Pain<br>red by MD, monitor use and<br>ositioning and body alignment<br>resident allows. Staff to<br>eeds, i.e changes in body<br>grimacing. Care plan also<br>e use and effectiveness of<br>odate family with any changes<br>omfort including loneliness<br>ed. The facility failed to<br>are for R83 to include | F 309               |   |           |                                     |

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|                          |  | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                     |    |  | FORM      | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |    | CONSTRUCTION   | (X3) DATE | E SURVEY<br>IPLETED                 |
|                          |  | 245581  | B. WING _           |    |  | 01/       | 16/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER   | ·   |                     | ST | REET ADDRESS, CITY, STATE, ZIP CODE  | -         |                                     |
| FAIR OA                  | KS LODGE   |   |                     |    | 1 SHADY LANE DRIVE<br>ADENA, MN 56482  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | C  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | Continued From pa  | lge 16  | F 30                | 09 |  |           |                                     |
|                          | residents' pills. R83<br>LPN-A, "Oh why do<br>cried out "ow" agair   | B cried out and sighed loudly to<br>bes my hip hurt so bad," then<br>n. LPN-A did not acknowledge<br>d dishing up other residents'  |                     |    |  |           |                                     |
|                          | out "ow" in pain in t  | 9:08 a.m. R83 continued to call<br>the hallway next to the LPN,<br>give R83 medication or<br>way.   |                     |    |  |           |                                     |
|                          | medication crushed<br>LPN-A told R83 he<br>yet. LPN-A told hou<br>available to transfer  | 9:13 a.m. LPN-A provided<br>d in applesauce with a spoon.<br>was not going to go to bed<br>usekeeping there was no one<br>r R83 to bed yet and he can't<br>3 was seated in the day area<br>s near the TV. |                     |    |  |           |                                     |
|                          | legs, and chest rea<br>much. R83 describe<br>that comes and goe<br>R83 described his p<br>running over his he<br>stated his wrist hurt<br>lays too long he has<br>near his thigh and t<br>stated pain goes fro<br>10 it lasts for 8-10 s<br>noise when he is hu<br>they will get him so<br>"Sometimes I get so<br>don't." R83 was grin<br>visibly in pain during | -   |                     |    |  |           |                                     |
|                          | R83's call light after   | 9:53 a.m. the surveyor pushed<br>r he requested he wanted to<br>his bottom was hurting. R83   |                     |    |  |           |                                     |

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|                          |   | AND HUMAN SERVICES   |  |     |   | FORM  | 02/20/2015<br>APPROVED<br>0938-0391 |  |  |  |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  |     | LE CONSTRUCTION   | (X3) DATE                                     | E SURVEY<br>PLETED                  |  |  |  |
|                          |   | 245581   | B. WING                                  |     |   | 01/   | 16/2015                             |  |  |  |
| NAME OF                  | PROVIDER OR SUPPLIER  |  | ·  | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | <u>,                                     </u> |                                     |  |  |  |
| FAIR OA                  | KS LODGE  |  | 201 SHADY LANE DRIVE<br>WADENA, MN 56482 |     |   |   |                                     |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                       |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE  | (X5)<br>COMPLETION<br>DATE          |  |  |  |
| F 309                    | stated the staff see<br>but it doesn't really<br>hurting. R83 stated<br>exercises for awhile<br>because he couldn'<br>him to. R83 stated<br>they didn't even wa<br>hurt too much, they<br>On 01/13/2015, at 7<br>(RN)-A and NA-C w<br>from wheelchair to<br>feet and cried out, "<br>R83 to lean forward<br>arms. RN-A and NA<br>again, hold on and<br>loudly, and NA-C to<br>continued to cry out<br>and saying "ow" for<br>and was still grimad<br>breath after he was<br>On 1/13/15, at 3:35<br>waking up from a n<br>his legs with any me<br>On 01/14/2015, at 7<br>performing R83's m<br>hurt all over. NA-B<br>complaints of pain.<br>hurt so bad and his<br>his leg to put socks<br>wincing in pain. R83<br>grimacing and sight<br>attempted to put R8<br>"Oh my neck, back<br>were put on. R83 st<br>NA-B did not respo | m to think the cushion helps,<br>help keep his bottom from<br>he use to do therapy<br>e and then they passed him up<br>'t do the things they wanted<br>he had PT and pretty soon<br>nt to try anymore because it<br>' gave up.<br>10:07 a.m. registered nurse<br>vere observed transferring R83<br>bed. R83 was unable to lift his<br>'I can't." RN-A and NA-C told<br>d and put a sling under both<br>A-C told R83 to lean forward<br>stand up. R83 cried out "ow"<br>old him to use his legs. R83<br>t, hold his breath, moaning<br>the duration of the transfer<br>cing, moaning and holding his<br>transferred into bed. | F3                                       | 309 |   |   |                                     |  |  |  |

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| CENTER                   | RS FOR MEDICARE  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     | C   | FORM<br>MB NO. | 02/20/2015<br>APPROVED<br>0938-0391 |
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|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | LE CONSTRUCTION   |                | E SURVEY<br>PLETED                  |
|                          |  | 245581   | B. WING             |   | 01/            | 16/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                |                                     |
| FAIR OA                  | KS LODGE   |  |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |                |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE           | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | transfer R83 into his<br>grimacing and callir<br>was yelling, "I'm not<br>NA-B told R83, "cor<br>his back hurt "so d<br>get you some Tylen<br>R83's back feels be<br>God no it doesn't fe<br>acknowledge R83's<br>going to brush his to<br>would be back to ta<br>continued to cry out<br>pushed R83 up to b<br>water on. R83 conti<br>as he was grimacin<br>brushing.<br>On 01/14/2015, at 8<br>and LPN-A did not a<br>continued to dish up<br>continued to dish up<br>continued to dish up<br>continued to say "ov<br>LPN-A told R83, "H<br>ready here."<br>On 01/14/2015, at 8<br>and saying "ow" in t<br>R83 if he wanted to<br>stated he did want t<br>staff person that R8<br>was brought to sit in<br>On 01/14/2015, at 9 | age 18<br>s wheelchair. R83 was<br>ng out, "Oh my back." R83<br>t ready, ow, I cant take this."<br>me on." R83 was calling out<br>amn bad." RN-A stated, "We'll<br>ool or something." NA asked if<br>etter and R83 stated, "No, Oh<br>eel better." NA-A did not<br>s pain and told R83 he was<br>eeth and RN-A stated she<br>ake R83 to breakfast. R83<br>t, "Oh my back" as NA-A<br>pathroom sink and turned the<br>inued to call out "ow, ow, ow",<br>ag and panting with teeth<br>8:18 a.m. R83 cried out "ow",<br>acknowledge him. LPN-A<br>p other residents' pills. R83<br>w" and grimace and pant.<br>old on, I am just getting it<br>8:21 a.m. R83 yelling out in<br>. LPN-A gave R83 pills in<br>8:59 a.m. R83 was grimacing<br>the dining room. LPN-A told a<br>33 was having pain and R83<br>n the back of dayroom.<br>9:22 a.m. NA-C came to<br>R83 he could lay down in a | F 309               |   |                |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |  |    |   | FORM     | : 02/20/2015<br>APPROVED<br>. 0938-0391 |  |  |  |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · /                                      |    | LE CONSTRUCTION   | (X3) DAT | E SURVEY<br>IPLETED                     |  |  |  |
|                          |  | 245581   | B. WING                                  |    |   | 01/      | 16/2015                                 |  |  |  |
| NAME OF I                | PROVIDER OR SUPPLIER   |  | •  | S  | TREET ADDRESS, CITY, STATE, ZIP CODE  | -        |   |  |  |  |
| FAIR OA                  | KS LODGE   |  | 201 SHADY LANE DRIVE<br>WADENA, MN 56482 |    |   |          |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                       | x  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE              |  |  |  |
| F 309                    | On 01/14/2015, at 9<br>were observed assi<br>wheelchair. R83 sta<br>really hurt. NA-C sta<br>sore since he came<br>cause. R83 was ho<br>grimacing, trying to<br>calling out, "Oh my<br>"Why does everythi<br>continued to grimac<br>told NA-C that R83<br>him down. NA-A an<br>had a lot of pain an-<br>in bed. The NAs co<br>whenever he is in h<br>they move or transf<br>R83 has been in pa<br>level depends on the<br>reviewed their care<br>was nothing on their<br>plan about pain. N/<br>take R83's pain awa<br>pain medications w<br>that the only non-ph<br>R83's pain was to la<br>On 1/14/15, at 7:30<br>had pain since his c<br>didn't work. NA-B s<br>looks like he is dyin<br>pain limits his daily<br>bed the most. NA-E<br>he feels horrible an<br>die. NA-B stated the<br>intervention for R83<br>him once in a while<br>NA-B stated R83 so | 9:24 a.m. NA-C and NA-A<br>sting R83 into bed from<br>ated his shoulders and back<br>ated R83's back had been<br>a in and the weather was a<br>lding his breath in the lift,<br>catch his breath. R83 was<br>neck." R83 asked the NAs,<br>ng have to hurt so bad." R83<br>ce and cry out in bed. NA-A<br>always does this when you lay<br>d NA-C confirmed that R83<br>d he is the most comfortable<br>nfirmed that R83 had pain<br>is wheelchair or whenever<br>er him. Both NAs confirmed<br>in since admission and his<br>e time of day. Both NAs<br>sheet and stated that there<br>r care sheets from the care<br>A-A stated the surgery did not<br>ay like it should have, and the<br>ere not working. NA-A stated<br>harmacological intervention for | F3                                       | 09 |   |          |   |  |  |  |

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|                          |  | AND HUMAN SERVICES   |                    |                                     |  | FORM | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                | ) MULTIPLE CONSTRUCTION<br>BUILDING |  |      | E SURVEY<br>PLETED                  |
|                          |  | 245581   | B. WING            |                                     |  | 01/- | 16/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                    |                                     | TREET ADDRESS, CITY, STATE, ZIP CODE   |      |                                     |
| FAIR OA                  | KS LODGE   |  |                    |                                     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482  |      |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | On 01/14/2015, at 8<br>has daily pain in his<br>possible abscess. F<br>more because of hi<br>mostly has pain with<br>acceptable pain lev<br>perform transfers a<br>activities. RN-A stat<br>pain and doesn't alv<br>but felt R83's pan w<br>medications. RN-A<br>since admission an<br>or nursing rehab. R<br>R83's pain level, but<br>depending on what<br>confirmed R83's ca<br>non-pharmacologic<br>rest.<br>On 01/14/2015, at 8<br>has chronic pain. N<br>didn't work and that | 3:28 a.m. RN-A stated R83<br>s back after back surgery and<br>RN-A stated R83 is in bed<br>is back. RN-A stated R83<br>h transfers. She added an<br>rel for R83 is when he can<br>nd can perform his daily<br>ted R83 complains daily of<br>ways ask for pain medication,<br>vas controlled with prn<br>stated R83 had been in pain<br>d no longer receives PT, OT<br>N-A stated she is not sure of<br>ut felt it was mild to moderate<br>he was doing. RN-A<br>re plan and only contained the<br>al intervention of letting him<br>3:40 a.m. NA-J stated that R83<br>IA-J stated R83's surgery<br>t nothing seems to work. NA-J | F 3                | 309                                 | DEFICIENCY)  |      |                                     |
|                          | stated R83 has pair<br>yanks his body with<br>R83's pain severely<br>stated she felt that<br>but they try to do wi<br>stated what helps F<br>NA-J stated she know<br>working by talking to<br>reposition him withous<br>stated that every time   | n 24/7 and if R83 moves he<br>a sharp pain. NA-J stated that<br>/ limits his daily living. NA-J<br>R83's pain was not controlled,<br>hat the doctor says. NA-J<br>R83's pain is if he lays in bed.<br>ows when the medicine is<br>o him and they can toilet and<br>put R83 screaming. NA-J<br>ne you move or turn R83 he   |                    |                                     |  |      |                                     |
|                          | R83's daily pain wa<br>yelling out in pain d<br>repositioned every   | pain. NA-J stated that she felt<br>s between 7-8 and that he is<br>aily. NA-J stated R83 is to be<br>2 hours and use his back<br>macological interventions.  |                    |                                     |  |      |                                     |

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|                          |  | AND HUMAN SERVICES   |                     |   | FORM                     | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | PLE CONSTRUCTION  | (X3) DATE                | E SURVEY<br>IPLETED                 |
|                          |  | 245581   | B. WING             |   | <b>01</b> / <sup>.</sup> | 16/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                          |                                     |
| FAIR OA                  | KS LODGE   |  |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |                          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                     | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | On 01/14/2015, at 8<br>sees R83 in pain m<br>pain.<br>On 1/14/15, at 9:45<br>have pain. LPN-C s<br>is controlled depend<br>busy and not bored<br>stated an acceptab<br>be 0, comfortable, p<br>pain medication wa<br>and did not want to<br>stated if R83 is bore<br>stated R83's averag<br>he moves 5-8, and<br>LPN-C stated, "I do<br>for him, if he has pa<br>more of a fall risk."<br>On 01/14/2015, at 1<br>complains more wh<br>down. LPN-A stated<br>down. LPN-A stated<br>chronic. She stated<br>out during transfers<br>sensitive area. LPN<br>acceptable level of<br>should have pain. I<br>anything for R83's p<br>narcotics. LPN-A st<br>not debilitating. LPN<br>was calling out mor<br>LPN-A stated the m<br>the more his pain is<br>that the facility has<br>for different pain me<br>emailed the directo<br>her to quit asking for | age 21<br>8:50 a.m. LPN-B stated she<br>nost days, and that he jumps in<br>6 a.m. LPN-C stated R83 does<br>stated she can tell if R83's pain<br>ding on his mood, and if he is<br>1 he won't complain. LPN-C<br>de level of pain for him would<br>pain free. LPN-C stated his<br>as effective if he was happy<br>lay down as much. LPN-C<br>ed, then he has pain. LPN-C<br>ge pain if he lays still is 2-3, if<br>it depends on what's wrong.<br>on't know what more we can do<br>ain medications then he is<br>12:55 p.m. LPN-A stated R83<br>hen he is up and wants to lay<br>d R83 always wants to lay<br>d she felt R83's pain was<br>a she would expect R83 to call<br>s because his back is a<br>I-A stated she felt an<br>pain for R83 is none, no one<br>LPN-A stated it is hard to do<br>pain, and R83 is sensitive to<br>tated she felt that R83's pain is<br>N-A stated that she felt R83<br>re, and he likes attention.<br>hore you pay attention to him,<br>a exaggerated. LPN-A stated<br>asked the doctor many times<br>edications, and the doctor<br>r of nursing (DON) and told<br>or pain medications, so that is<br>ng. LPN-A stated that R83 had | F 309               |   |                          |                                     |

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|                          |   | AND HUMAN SERVICES   |                                       |     |   | FORM             | 02/20/2015<br>APPROVED<br>0938-0391 |  |  |  |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                                   |     | E CONSTRUCTION  | (X3) DATE        | E SURVEY<br>PLETED                  |  |  |  |
|                          |   | 245581   | B. WING                               |     |   | 01/ <sup>.</sup> | 16/2015                             |  |  |  |
| NAME OF F                | PROVIDER OR SUPPLIER  |  | STREET ADDRESS, CITY, STATE, ZIP CODE |     |   |                  |                                     |  |  |  |
| FAIR OA                  | KS LODGE  |  |                                       |     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482   |                  |                                     |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                    |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE             | (X5)<br>COMPLETION<br>DATE          |  |  |  |
| F 309                    | a history of alcoholi<br>from hospital his liv<br>requiring low dose p<br>On 01/14/2015, at 2<br>R83 did not trigger<br>CAA. RN-A stated F<br>on 12/23/14, and has<br>stabbing, lower back<br>laying down alleviat<br>it worse. RN-A conf<br>dated 12/23/14, that<br>to die. The assessm<br>prevents R83 from<br>performance of his<br>participation and R8<br>because of his pain<br>aware that R83 was<br>(MD name) and the<br>were aware that R8<br>RN-A stated she wo<br>in pain. RN-A stated<br>R83's pain was mod<br>in December 2014,<br>assessment. RN-A<br>really does not wan<br>R83's pain medicat<br>antibiotic on Januar<br>repeat MRI. RN-A s<br>of what we can do,<br>medications and do<br>think of anything els<br>pain." RN-A confirm<br>regimen.<br>On 01/14/2015, at 3<br>Interviewed. RN-C s | sm and when he came back<br>er function was impaired<br>pain medication.<br>2:06 p.m. RN-A confirmed that<br>for pain on the admission<br>R83 was reassessed for pain<br>ad complaints of continuous,<br>k pain. LPN-A stated that<br>tes his pain and activity makes<br>firmed the pain assessment<br>at R83 will voice he just wants<br>nent also indicated R83's pain | F 3                                   | 309 |   |                  |                                     |  |  |  |

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|                          |   | AND HUMAN SERVICES   |                   |     |   | FORM                          | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |   | 245581   | B. WING           | i   |   | 01/ <sup>.</sup>              | 16/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                   |     | TREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FAIR OA                  | KS LODGE  |  |                   |     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | a fax was sent to G<br>RN-A stated they w<br>anything else for pa<br>stated that R83 car<br>medication for mod<br>Vicodin was put on<br>R83 now gets Tyler<br>(narcotic medicatio<br>RN-A stated R83's<br>about R83's kidney<br>meanwhile they kee<br>RN-C stated R83's<br>receive Vicodin as<br>confused and falling<br>to him on and off th<br>no way to live. RN-C<br>R83 does not have<br>chemical depender<br>RN-C R83's history<br>and liver function. In<br>nothing in R83's me<br>alcoholism history a<br>prescribing other na<br>On 01/15/2015, at 8<br>interviewed and state<br>medical director inv<br>management.<br>On 01/15/2015, at 8<br>interviewed. COTA<br>discharged from the<br>COTA stated that R<br>problem. The COTA<br>and R83's family th<br>not helping and R85 | ot get any better. RN-C stated<br>aNP-A to address R83's pain.<br>were told 83 was not getting<br>ain and to stop asking. RN-C<br>me back on Vicodin (narcotic<br>lerate to severe pain).The<br>hold due to behaviors and<br>nol and the Fentanyl patch<br>n through patch on skin).<br>doctor was more concerned<br>'s, and less about his liver,<br>ep waiting for improvement.<br>family did not want R83 to<br>they did not want R83<br>g. RN-A stated R83 has stated<br>hat he wants to die and this is<br>C and DON confirmed that<br>a clinical diagnosis of<br>ncy. GNP-A has explained to<br>of alcoholism and poor renal<br>DON confirmed there was<br>edical record diagnosing<br>and rationale for not<br>arcotic pain medications.<br>8:09 a.m. the DON was<br>atted the facility did not get the<br>volved with R83's pain | F                 | 309 |   |                               |                                     |

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|                          |  | AND HUMAN SERVICES  |                     |   | FORM             | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|---|------------------|-------------------------------------|
|                          |  | · /   | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED   |                  |                                     |
|                          | 245581   |   | B. WING             |   | 01/ <sup>.</sup> | 16/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                  |                                     |
| FAIR OAKS LODGE          |  |   |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |                  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE             | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | limited his ability to<br>R83 does not get n<br>walking schedule b<br>stated R83 was una<br>services because of<br>pain was severe, ch<br>COTA stated R83's<br>and it is a shooting<br>sits in his chair. CO<br>her that he wishes if<br>pain, and wished it<br>stated R83's feeling<br>stated that the fami<br>medication because<br>COTA stated when<br>and disoriented and<br>medication because<br>COTA stated when<br>and disoriented and<br>medication in the m<br>in bed was really ha<br>when R83 was rolle<br>and going from sup<br>say "that kills me do<br>She stated she let t<br>much pain and ask<br>medication because<br>the doctor and fami<br>COTA stated R83 wa<br>1/2/15.<br>On 01/15/2015, at 9<br>interviewed. GNP-A<br>pain. GNP-A stated<br>things for pain, and<br>him falling they tool<br>pain patch. GNP-A<br>best thing in the wo | age 24<br>participate. The COTA stated<br>ursing rehab and was not on a<br>ecause of pain. The COTA<br>able to receive range of motion<br>of pain. The COTA stated R83's<br>hronic and every day. The<br>pain was when he is moving<br>pain. R83 winces when he just<br>OTA stated R83 had stated to<br>he would die because of the<br>would just go away. COTA<br>gs were understandable. COTA<br>dy and doctors limit R83's pain<br>e it made R83 disoriented.<br>R83 was admitted he was lost<br>d when he was taken off pain<br>s more clear. The COTA stated<br>before he got his pain<br>norning. COTA stated sitting up<br>ard for R83. COTA stated<br>before he got his pain<br>norning when your doing that."<br>the nurse know he had that<br>ed if R83 can have pain<br>e he was only on Tylenol per<br>ily, and they decided not to.<br>did not improve at all during<br>as discharged from therapy<br>9:20 a.m. the GNP-A was<br>A stated R83 was in constant<br>I R83 has been on so many<br>I stated because of their fear of<br>k away narcotics and left the<br>stated the brace was not the<br>orld and R83 constantly keeps<br>a stated R83 tells her he would |                     |   |                  |                                     |

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|  |   | AND HUMAN SERVICES   |                    |                |   | FORM             | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA<br>AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  |                    | E CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED   |                  |                                     |
|  |   | 245581   | B. WING            |                |   | 01/ <sup>.</sup> | 16/2015                             |
| NAME OF PI   | ROVIDER OR SUPPLIER   |  |                    | S              | TREET ADDRESS, CITY, STATE, ZIP CODE  |                  |                                     |
| FAIR OAKS LODGE  |   |  |                    |                | 01 SHADY LANE DRIVE<br>VADENA, MN 56482   |                  |                                     |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |                | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE             | (X5)<br>COMPLETION<br>DATE          |
|  | GNP-A stated R83 main floor was the f<br>main floor was the f<br>when R83 was upsi<br>GNP-A stated she t<br>pain and he wanted<br>surgeon and do and<br>an abscess, and the<br>something. GNP-A<br>everything, at one p<br>pain medication exc<br>difference. [R83's] p<br>matter what we give<br>cognitive level decli<br>times he will not ge<br>"Nothing we have d<br>of pain. Not sure is<br>kidneys bad, livers<br>nothing has change<br>either groggy or his<br>has been a long ha<br>pain staying the sar<br>On 01/15/2015, at 3<br>(FM)-A was intervie<br>concerned regardin<br>doctor about R83's<br>MD says R83 can of<br>that. FM-A stated, "<br>this much pain. I was<br>surgery he fell down<br>R83 has fallen 2-3 t<br>the hospital and did<br>stated he was conc<br>falls only a week aff<br>complaining of pain<br>FM-A stated he was | rink when she sees him.<br>was still having pain and the<br>best floor for him because<br>tairs he dwelled on his pain.<br>talked to his MD about R83's<br>to wait 6 weeks per the<br>other MRI as R83 could have<br>en surgically they would do<br>a stated, "We have tried<br>boint we took [R83] off all his<br>cept for Tylenol with no<br>pain stayed the same no<br>e him." GNP-A stated if R83's<br>ines and he falls one too many<br>t better. GNP-A stated,<br>lone has changed [R83's] level<br>he's a surgical candidate,<br>worse. Nothing we have done,<br>ed the level of pain. R83 is<br>back hurts." GNP-A stated it<br>ul with R83 and his level of<br>me.<br>3:25 p.m. family member<br>ewed. FM-A stated he was<br>ng the follow up from the<br>pain. FM-A stated that if the<br>do better then R83 would want<br>I don't know why he is still in<br>as told that after his back<br>in a couple times." FM-A stated<br>times since he got back from<br>a not see the doctor. FM-A<br>cerned after R83 was having<br>ter back surgery and was<br>h, and has not seen the doctor.<br>s concerned that there was no<br>something happened to R83's | F3                 | 309            |   |                  |                                     |

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|                          |  | AND HUMAN SERVICES  |                    |     |  | FORM             | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|------------------|-------------------------------------|
|                          |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                    |     | (X3) DATE SURVEY<br>COMPLETED  |                  |                                     |
|                          |  | 245581  | B. WING            |     |  | 01/ <sup>.</sup> | 16/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                  |                                     |
| FAIR OAKS LODGE          |  |   |                    |     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482  |                  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE               | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | Continued From pa  | ige 26  | FS                 | 309 |  |                  |                                     |
|                          | satisfied with his pakeep saying they and they don't do anythic worried about rocking his pain. R83 stated when he was laying shooting pain when seems like nothing want to be dead, not have been different about and felt I want wanted to die becaut that waiting to go to sad, and says that's On 01/15/2015, at 4 and DON were inter they can assess, but when a MD is adam something else for did not document they did not document they did not document they did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when a MD is adam something else for did not document they can assess, but when R83 is at rest gets up he is wincir feels they had relating R83 was not pain fit R83 was not pain fit R83's statements of they can assess at they had relating R83's statements of they can be added to they can be added | 4:16 p.m. the administrator<br>rviewed. Administrator stated<br>ut asked what they can do<br>nant about not giving<br>pain. DON stated that LSW<br>ne statements about wanting<br>that R83 meant he was ready |                    |     |  |                  |                                     |

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245581 B. WING 01/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE FAIR OAKS LODGE **WADENA, MN 56482** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 309 Continued From page 27 F 309 yesterday about R83's pain control, and they are still working on non-med therapies and other interventions for side effects. MD-A stated she was not aware of what the non-pharmacological interventions were being tried. The nursing progress notes following surgery to current documented: -12/23/14, at 15:34 R83 returned to the facility after hospitalization, and the note identified R83 continued to be in pain. No prn medication or non-pharmacological interventions documented for R83's pain. -12/24/14, at 6:26 a.m. identified R83 had complained of back pain with verbal and non-verbal indicators of pain. Writer indicates that R83 has scheduled pain medications. No prn medication or non-pharmacological interventions documented for R83's pain. -12/24/14, at 21:51 identified R83 was showing signs and symptoms of pain with any activity and repositioning when he is up out of bed in wheelchair. No prn medication or non-pharmacological interventions documented for R83's pain. -12/25/14, at 10:35 a.m. R83 requested medication for leg pain rated 8/10. Tylenol given at 10:35 a.m. and documented as effective. -12/25/14, at 14:10 R83 has complaints of bilateral leg pain and stated it was a constant ache. Writer states Tylenol was given, none recorded since 10:35 a.m. R83 got up for dinner and returned to bed right after, still stating he had leg pain after being placed in bed. Writer indicated that R83 was resting with eyes closed since that then. -12/25/14, at 2158, R83 continued to have complaints of pain to his lower back with scheduled Tylenol given at HS with some relief.

FORM CMS-2567(02-99) Previous Versions Obsolete

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|                          |   | AND HUMAN SERVICES  |                    |     |   | FORM                          | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |   | 245581  | B. WING            | i   |   | 01/                           | 16/2015                             |
| NAME OF I                | PROVIDER OR SUPPLIER  | •   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | -                             |                                     |
| FAIR OAKS LODGE          |   |   |                    |     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | No further prn medi<br>of non-pharmacolog<br>pain.<br>-12/26/14, at 7:21 a<br>back pain with verb<br>pain. Writer noted t<br>medications. No prn<br>non-pharmacologic<br>for R83's pain.<br>-12/26/14, at 22:14<br>symptoms of back p<br>guarding. Writer sta<br>has been helpful. R<br>symptoms of pain v<br>repositioning. No fu<br>non-pharmacologic<br>for R83's pain.<br>-12/27/14, at 1458 I<br>moaning with transf<br>No prn medication of<br>interventions docum<br>-12/28/14, at 14:28<br>symptoms of pain v<br>repositioning. No pr<br>non-pharmacologic<br>for R83's pain.<br>-12/30/14, at 15:27<br>lower back pain and<br>documented as effe<br>-12/31/14, at 1840<br>symptoms of back p<br>guarding. Writer sa<br>helpful.<br>-1/1/15, at 12:59 R8<br>transfers and repor<br>medication or non-p<br>documented for R8<br>-1/1/15, at 20:22 R8 | ication given or documentation<br>gical interventions for R83's<br>a.m. R83 was complaining of<br>val and non-verbal indicators of<br>hat R83 had scheduled pain<br>n medication or<br>ral interventions documented<br>R83 showing signs and<br>pain with facial grimacing and<br>ated that scheduled HS Tylenol<br>R83 was showing signs and<br>with any activity and<br>urther prn medication or<br>ral interventions documented<br>R83 was grimacing and<br>fers using the mechanical lift.<br>or non-pharmacological<br>nented for R83's pain.<br>R83 was showing signs and<br>with transfers and<br>rn medication or<br>ral interventions documented<br>R83 requested medication for<br>d rated pain 7/10. Tylenol was<br>ective.<br>R83 was showing signs and<br>pain with facial grimacing and<br>id that scheduled Tylenol was<br>ective.<br>R83 was showing signs and<br>pain with facial grimacing and<br>id that scheduled Tylenol was | F3                 | 309 |   |                               |                                     |

|                          |   | AND HUMAN SERVICES  |                   |     |   | FORM     | 02/20/2015<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | PLE CONSTRUCTION  | (X3) DAT | E SURVEY<br>IPLETED                 |
|                          |   | 245581  | B. WING           |     |   | 01/      | 16/2015                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -        |                                     |
| FAIR OAKS LODGE          |   |   |                   |     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | that both prn and the<br>only minimal relief f<br>back brace only pro-<br>further prn medicati<br>interventions docume<br>-1/2/15, at 21:36 R8<br>signs and symptom<br>and reports pain an<br>medication docume<br>non-pharmacologic<br>-1/3/15, at 19:11 R8<br>prn Tylenol given. N<br>effectiveness or oth<br>interventions docum<br>-1/4/15, at 19:11 R8<br>prn Tylenol given. N<br>effectiveness or oth<br>interventions docum<br>-1/4/15, at 6:38 a.m<br>pain. Writer indicate<br>medications. No prn<br>non-pharmacologic<br>for R83's pain.<br>-1/6/15, at 7:31 a.m<br>signs and symptom<br>documentation of e<br>-1/6/15, at 8:53 a.m<br>nurse and writer up<br>nurse said that she<br>-1/9/15, at 8:57 a.m<br>buttocks leaning up<br>reach his urinal. R8<br>entire time. No prn<br>non-pharmacologic<br>for R83's pain or m<br>-1/10/15, at 11:42 F<br>was going out with<br>to back. Tylenol not<br>15:06.<br>-1/12/15, at 11:06 a<br>noted his fall of 1/9/<br>R83's medications of | he scheduled Tylenol provide<br>for R83. Writer also noted that<br>ovided minimal relief. No<br>ion or non-pharmacological<br>nented for R83's pain.<br>33 has verbal and non-verbal<br>is of pain throughout the shift<br>of weakness to legs. No prn<br>ented or any documentation of<br>al interventions for R83's pain.<br>33 had back pain rated 9/10,<br>No documentation of Tylenol<br>ner non-pharmacological<br>nented.<br>1. R83 continued to have back<br>ed R83 had scheduled pain<br>n medication or<br>al interventions documented<br>1. R83 was grimacing and has<br>is of pain. Tylenol given, no<br>ffectiveness.<br>1. Call was received from MD's<br>dated her on R83's pain,<br>would update MD.<br>1. R83 was found sitting on his<br>o against his bed after trying to<br>33 complained of back pain the<br>medication or<br>al interventions documented<br>edical attention pursued.<br>833 was given prn Tylenol and<br>family to aid in his discomfort<br>documented effective until<br>1 GNP visited R83 and<br>(15. GNP made no changes to | F                 | 309 |   |          |                                     |

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| CENTERS FOR MEDICARE & MEDICAID SERVICES  | OMB NO. 0938-0391   |
|---|---|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) M  | IULTIPLE CONSTRUCTION     (X3) DATE SURVEY       ILDING     COMPLETED   |
| 245581 B. WI  | <sup>NG</sup> 01/16/2015  |
| NAME OF PROVIDER OR SUPPLIER  | STREET ADDRESS, CITY, STATE, ZIP CODE   |
| FAIR OAKS LODGE   | 201 SHADY LANE DRIVE<br>WADENA, MN 56482  |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE  | D PROVIDER'S PLAN OF CORRECTION (X5)<br>EFIX (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) DATE |
| <ul> <li>F 309 Continued From page 30<br/>hip pain and was given Tylenol. Tylenol<br/>documented effective.</li> <li>-1/14/15, at 8:33 a.m. R83 requested medication<br/>for back pain, Tylenol was administered and<br/>documented effective. R83 stated that as long as<br/>he is in bed there is no pain.</li> <li>The Pain Management Policy revised 4/09,<br/>identified that residents are screened for pain<br/>regularly through observing the resident during<br/>daily care and/or observing for signs and<br/>symptoms of pain.</li> <li>R51's care plan dated, 3/17/10, directed staff to<br/>observe skin with routine daily care, and to report<br/>to nurse any changes noted, and to observe for<br/>bruising as it is a potential side effect of aspirin<br/>therapy. The care plan also directed staff to<br/>complete weekly skin inspection with<br/>documentation of results.</li> <li>The quarterly MDS dated 12/29/14, indicated R51<br/>was cognitively intact and required assistance for<br/>all activities of daily living. The MDS indicated<br/>R51 had diagnoses which included degenerative<br/>joint disease, edema, Parkinson's, diabetes<br/>mellitus (DM) and osteoarthritis.</li> <li>During observation on 1/13/15, at 3:36 p.m. R51<br/>was seated in a wheelchair next to the bed.<br/>Observed one large dark purple bruise,<br/>approximately 3 x 3 inches on the resident's right<br/>forearm, also observed 3 smaller dark purple<br/>bruises on resident's left hand and 1 small bruise<br/>on the right forearm happened a couple of days<br/>ago when her arm bumped the grab bar on the<br/>bed. R51 stated the bruises on the left arm and<br/>hand also happened a couple days ago and were<br/>caused when staff assist her left arm up to the</li> </ul> | = 309   |

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|                          |  | AND HUMAN SERVICES   |                     |   | FORM             | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|---|------------------|-------------------------------------|
|                          |  |  | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED   |                  |                                     |
|                          |  | 245581   | B. WING             |   | 01/ <sup>.</sup> | 16/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER   | •  |                     | TREET ADDRESS, CITY, STATE, ZIP CODE  | -                |                                     |
| FAIR OA                  | KS LODGE   |  |                     | 01 SHADY LANE DRIVE<br>NADENA, MN 56482   |                  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE             | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | grab bar next to the<br>her shirt to assist he<br>by accident get her<br>reported that she de<br>bruises easily. R51<br>about the bruises, t<br>had seen the bruises<br>dressed and undres<br>During medical rece<br>was evident to indic<br>right and left forear<br>Skin assessment d<br>was at risk for skin<br>mobility, DM, edem<br>and bladder inconti<br>directed licensed st<br>assessments.<br>During interview on<br>confirmed she assis<br>including dressing of<br>R51 has real thin sl<br>careful when movin<br>did not notice any m<br>had black and blue<br>hands. NA-B repor<br>those bruises on R5<br>asked if NA-B had<br>nurses, she stated,<br>always had those b<br>she came here to th<br>During interview on<br>reported R51 bruise<br>confirm if R51 currer<br>reviewing the medic | a toilet. R51 stated staff grab<br>er left arm up to the toilet and<br>skin in with her clothes. R51<br>oes take a daily aspirin and<br>1 stated she had not told staff<br>then stated she was sure staff<br>es because they help her get<br>ssed everyday.<br>ord review, no documentation<br>cate R51 had bruises on the<br>ms and left hand.<br>ated 9/29/14, indicated R51<br>breakdown related to limited<br>ta, peripheral vascular disease<br>nence. The skin assessment<br>taff to complete weekly skin<br>1/14/15, at 9:57 a.m. NA-B<br>sted R51 with daily cares<br>on 1/14/15. NA-B reported<br>kin and staff have to be very<br>ng her arms. NA-B stated she<br>new bruises, but did state R51<br>bruises on both arms and<br>ted the nurses all know about<br>51's arms and hands. When<br>reported the bruises to the<br>no because the resident has<br>pruises on her skin ever since | F 309               |   |                  |                                     |

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|   |  | AND HUMAN SERVICES   |                    |     |   | FORM | : 02/20/2015<br>APPROVED<br>: 0938-0391 |
|---|--|--|--------------------|-----|---|------|---|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  | . ,  |                    |     | (X3) DATE SURVEY<br>COMPLETED   |      |   |
|   |  | 245581   | B. WING            |     |   | 01/  | 16/2015                                 |
| NAME OF F   | PROVIDER OR SUPPLIER   |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE   | •    |   |
| FAIR OAKS LODGE                                       |  |  |                    |     | 201 SHADY LANE DRIVE<br>NADENA, MN 56482  |      |   |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE | (X5)<br>COMPLETION<br>DATE              |
| F 309   | resident's bath days<br>progress notes, and<br>progress note docu<br>indicated no concer<br>time. LPN-A stated<br>inspection would ha<br>bath day) and confin<br>assessment docum<br>record related to sk<br>no staff had reporte<br>hands or arms. LPI<br>with R51 consistent<br>During interview on<br>DON stated staff ar<br>bruising during daily<br>nurses right away s<br>monitor the bruise in<br>resolved. The DON<br>to follow the care pl<br>documenting results | honitor bruises by<br>es in the progress notes on the<br>s. LPN-A reviewed R51's<br>d LPN-A reported the last<br>mented was on 1/2/15, and<br>rns to body surface at that<br>I R51's last weekly skin<br>ave been on 1/9/15 (R51's<br>rmed that the weekly skin<br>the that the weekly skin<br>the entation was missing in the<br>in condition. LPN-A confirmed<br>ed R51 having any bruising to<br>N-A stated she does not work<br>tly, and works all three floors.<br>1/14/15, at 12:47 p.m. the<br>re expected to observe for<br>y cares and report bruises to<br>so the nurse can assess and<br>n the progress notes until<br>N confirmed staff are expected | F3                 | 309 |   |      |   |
| F 314<br>SS=D   | September 13, 201<br>system in place for<br>treatment, and docu<br>non-pressure woun<br>483.25(c) TREATM<br>PREVENT/HEAL P   | 1, indicated the facility had a<br>the prevention, identification,<br>umentation of pressure and<br>ds.<br>ENT/SVCS TO   | F۵                 | 314 |   |      | 2/16/15                                 |
|   | resident, the facility who enters the facil  | ressure sores unless the   |                    |     |   |      |   |

Facility ID: 00679

If continuation sheet Page 33 of 44
| MEDICARE   | & MEDICAID SERVICES  | (¥2) MU   |   | O  | RINTED: 02/20/2015<br>FORM APPROVED<br>MB NO. 0938-0391<br>(X3) DATE SURVEY   |
|--|--|---|---|--|---|
|  | IDENTIFICATION NUMBER:   |   |   |  | COMPLETED   |
|  | 245581   | B. WING   | i   |  | 01/16/2015  |
| OR SUPPLIER  | •  |   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | •   |
| GE   |  |   |   |  |   |
| CH DEFICIENC   | Y MUST BE PRECEDED BY FULL   |   |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE COMPLÉTION   |
| ual's clinical<br>ere unavoida<br>re sores rece<br>s to promote<br>t new sores<br>EQUIREMEN<br>I on observar<br>the facility f<br>ed at risk for<br>ary care and<br>for 2 of 2 res<br>e identified a<br>gs include:<br>quarterly Min<br>4, indicated F<br>eral vascular<br>ovascular ac<br>egia. The M<br>vely intact, re<br>aff to physica<br>rs, dressing<br>ed at risk for<br>d 2 unstages<br>in evolution<br>aneous tissum<br>mended R49<br>to chair and<br>current care<br>off load (reli-<br>cliner, wear a<br>uards on in b<br>tion, update | condition demonstrates that<br>able; and a resident having<br>eives necessary treatment and<br>e healing, prevent infection and<br>from developing.<br>NT is not met as evidenced<br>tion, interview, and document<br>ailed to ensure residents<br>pressure ulcers received the<br>d treatment to promote healing<br>velopment of further pressure<br>sident (R49, R102) in the<br>t risk for pressure ulcers.<br>imum Data Set (MDS) dated<br>R49 had diagnoses including<br>disease, diabetes,<br>cident (stroke), and<br>IDS also indicated R49 was<br>equired extensive assistance<br>ally help him with bed mobility,<br>and toileting. R49 was<br>developing pressure ulcers,<br>able suspected deep tissue<br>(a pressure related injury to<br>les under intact skin) and<br>have a pressure relieving<br>bed.<br>plan dated 11/24/14, instructed<br>ieve pressure) heels in bed<br>a left heel derma saver, have<br>red and recliner, weekly skin<br>physician on skin changes,  | F   | 314   | Resident #49 and #120 have been<br>assessed by the NM of their unit ar<br>not developed any skin impairment<br>to deficient practice.<br>Resident #49 and #120 care plans<br>been reviewed and updated.<br>Resident #49 and # 120 care plan<br>NAR group assignment sheet was<br>reviewed for proper offloading<br>requirements by LN, and are appro<br>All residents at FOL who require<br>repositioning assistance may be af<br>by this deficient practice.<br>All residents have TTT assessmen<br>completed quarterly and PRN, and<br>interventions implemented as appro<br>All residents care plans have been<br>reviewed and updated regarding<br>repositioning.<br>Nursing staff will receive education<br>skin care and pressure ulcer preve<br>including following care plans for to<br>and repositioning.including followin<br>group assignments which they are<br>carry. Group assignments reveal to<br>repositioning and assistive devices<br>residents require.  | on<br>ntion<br>pileting<br>g their<br>to<br>bileting,   |
|  | A MEDICARE<br>CHENCIES<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>CTION<br>C | CTION       IDENTIFICATION NUMBER:         245581         R OR SUPPLIER         GE         SUMMARY STATEMENT OF DEFICIENCIES<br>ACH DEFICIENCY MUST BE PRECEDED BY FULL<br>BULATORY OR LSC IDENTIFYING INFORMATION)         ued From page 33         ual's clinical condition demonstrates that<br>ere unavoidable; and a resident having<br>the sores receives necessary treatment and<br>es to promote healing, prevent infection and<br>it new sores from developing.         EQUIREMENT is not met as evidenced         I on observation, interview, and document<br>, the facility failed to ensure residents<br>ed at risk for pressure ulcers received the<br>sary care and treatment to promote healing<br>event the development of further pressure<br>for 2 of 2 resident (R49, R102) in the<br>e identified at risk for pressure ulcers. | IMEDICARE & MEDICAID SERVICES           DENCIES<br>CTION         (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:         (X2) MUI<br>A. BUILD           245581         B. WING           COR SUPPLIER         245581         B. WING           GE         SUMMARY STATEMENT OF DEFICIENCIES<br>CHO DEFICIENCY MUST BE PRECEDED BY FULL<br>BULATORY OR LSC IDENTIFYING INFORMATION)         ID<br>PREF<br>TAGE           ued From page 33<br>ual's clinical condition demonstrates that<br>ere unavoidable; and a resident having<br>tre sores receives necessary treatment and<br>as to promote healing, prevent infection and<br>it new sores from developing.         F 3<br>F 4<br>F 4<br>F 4<br>F 4<br>F 4<br>F 4<br>F 4<br>F 4<br>F 4<br>F 4 | IMEDICARE & MEDICAID SERVICES         DENCIES       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPI<br>A. BUILDING         245581       B. WING         GE       ID         SUMMARY STATEMENT OF DEFICIENCIES<br>GE DEFICIENCY MUST BE PRECEDED BY FULL<br>SULATORY OR LSC IDENTIFYING INFORMATION)       ID         Ved From page 33       ID         ued From page 33       F 314         res cores receives necessary treatment and<br>es to promote healing, prevent infection and<br>it new sores from developing.       F 314         EQUIREMENT is not met as evidenced       A on observation, interview, and document<br>is the facility failed to ensure residents<br>ed at risk for pressure ulcers received the<br>sary care and treatment to promote healing<br>event the development of further pressure<br>for 2 of 2 resident (R49, R102) in the<br>a identified at risk for pressure ulcers.         gs include:       guarterly Minimum Data Set (MDS) dated<br>4, indicated R49 had diagnoses including<br>eral vascular disease, diabetes,<br>ovascular accident (stroke), and<br>egia. The MDS also indicated R49 was<br>vely intact, required extensive assistance<br>aff to physically help him with bed mobility,<br>ers, dressing, and toileting. R49 was<br>ed at risk for developing pressure ulcers,<br>id 2 unstageable suspected deep tissue<br>is in evolution (a pressure related injury to<br>aneous tissues under intact skin) and<br>mended R49 have a pressure relieving<br>to chair and bed.         current care plan dated 11/24/14, instructed<br>off load (relieve pressure) heels in bed<br>cliner, wear a left heel derma saver, have<br>jards on in bed and recliner, weekly skin<br>tion, update physician on skin changes, <td>OF HEALTH AND HUMAN SERVICES       O         NEDICARE &amp; MEDICAIDS SERVICES       O         INEDICARE &amp; MEDICAIDS SERVICES       O         SIMMARY STATEMENT OF DEFICIENCIES       Resident #49         SUMMARY STATEMENT OF DEFICIENCIES       D         SUMMARY STATEMENT OF DEFICIENCIES       CO         SUMMARY STATEMENT IS NOT MET AS PROPHICAL ON THE APPROPHICAL ON TH</td> | OF HEALTH AND HUMAN SERVICES       O         NEDICARE & MEDICAIDS SERVICES       O         INEDICARE & MEDICAIDS SERVICES       O         SIMMARY STATEMENT OF DEFICIENCIES       Resident #49         SUMMARY STATEMENT OF DEFICIENCIES       D         SUMMARY STATEMENT OF DEFICIENCIES       CO         SUMMARY STATEMENT IS NOT MET AS PROPHICAL ON THE APPROPHICAL ON TH |

Facility ID: 00679

# PRINTED: 02/20/2015

| CENTE                    | RS FOR MEDICARE  | & MEDICAID SERVICES  |                     |  | OMB NO.   | APPROVE<br>0938-039       |
|--------------------------|--|--|---------------------|--|---|---------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                |                     | IPLE CONSTRUCTION<br>NG  |   | SURVEY<br>PLETED          |
|                          |  | 245581   | B. WING _           |  | <b>01</b> /1  | 6/2015                    |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP   | CODE  |                           |
| FAIR OA                  | KS LODGE   |  |                     | 201 SHADY LANE DRIVE<br>WADENA, MN 56482   |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETIO<br>DATE |
| F 314                    | when in wheel chai<br>R49's Nurse Aid Ca<br>directed staff to use<br>while in recliner and<br>pillow.<br>Review of R49's Nu<br>11/26/14, from gen<br>documented: "The<br>tissue injury of his I<br>length x 1 cm width<br>intact on his left late<br>were on and these<br>to be on patient's fe<br>injury. Keep shoes<br>assess the left hee<br>paint with betadine<br>next week."<br>During observation<br>at 7:05 a.m. nursing<br>were getting R49 d<br>his recliner. After F<br>proceeded to assis<br>his wheelchair. R49<br>that time. At 8:00 a<br>his room, and sat in<br>At 8:48 a.m. R49 w<br>room, and his feet | o brace) with transfers and  | F 31                |  | any skin<br>lete<br>its on various<br>to assure<br>n corrected<br>ositioning.<br>ete<br>rious shifts<br>e ulcers/skin<br>of wounds, x 3<br>t practice has<br>sure sores.<br>er next 3 |                           |

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|                          |  | AND HUMAN SERVICES   |                     |    |  | FORM      | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |    | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245581   | B. WING _           |    |  | 01/*      | 16/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | ST | TREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
| FAIR OA                  | KS LODGE   |  |                     | -  | )1 SHADY LANE DRIVE<br>/ADENA, MN 56482  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 314                    | stated R49 had a b<br>x 1 cm and "right fo<br>During observation<br>was sitting in his re-<br>on the foot rest of tl<br>on, and the derma a<br>bed and not on his<br>R49's Braden Scale<br>Sore Risk dated 12<br>mild risk for develop<br>R49's Tissue Tolera<br>11/25/14, indicated<br>pressure on R49's I<br>was to have his left<br>savers on.<br>R49's treatment ad<br>dated 1/14/15, direc<br>deep tissue injuries<br>for deep tissue injury to<br>then in wheelchair<br>document findings.<br>R49's Ulcer/Wound<br>indicating the follow<br>deep tissue injury to<br>11/24/14-length 2.1<br>width-contacted wo<br>12/10/14-length 1.7<br>12/29/14-length 1.5 | lack scab approximately 2 cm<br>oot is good."<br>on 1/15/15, at 3:30 p.m. R49<br>cliner, had his feet elevated up<br>he recliner. R49 had no shoes<br>saver boots were laying on his<br>feet.<br>e For Predicting Pressure<br>l/16/14, indicated R49 had<br>ping pressure ulcers.<br>ance Collection Sheet dated<br>skin issues related to<br>left heel, and indicated R49<br>theel off loaded with derma<br>ministration record (TAR)<br>cted staff to apply betadine to<br>s/feet topically one time a day<br>ry to left heel until scab falls<br>ht AFO with transfers and<br>c. Observe for redness and<br>d Documentation Form<br>ving measurements of R49's<br>o his left outer heel:<br>centimeters (cm) x 1.2 cm<br>ound nurse/next rounds.<br>B cm x 1.3 cm width- fluid filled<br>hage | F 3                 | 14 |  |           |                                     |

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|                          |  | AND HUMAN SERVICES  |                     |    |   | FORM                     | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|----|---|--------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |    | E CONSTRUCTION  | (X3) DATE                | E SURVEY<br>PLETED                  |
|                          |  | 245581  | B. WING             |    |   | <b>01</b> / <sup>.</sup> | 16/2015                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                     |    | TREET ADDRESS, CITY, STATE, ZIP CODE  |                          |                                     |
| FAIR OA                  | KS LODGE   |   |                     |    | 01 SHADY LANE DRIVE<br>VADENA, MN 56482   |                          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | <  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                     | (X5)<br>COMPLETION<br>DATE          |
| F 314                    | 1/14/15- continue to<br>not measured.<br>Reviewed R49's Pro-<br>1/14/14:<br>11/22/14- "Found da<br>side heel, not open-<br>discomfort, the area<br>applied heel guard<br>11/24/14- "Left outer<br>discoloration, occup<br>and said to continue<br>in recliner and in be<br>we are also to off lo<br>recliner, this was pu-<br>have wound nurse I<br>11/28/14-"Betadine<br>12/7/14-"Left outer<br>derma saver placed<br>folded blanket."<br>12/12/14- "Left need<br>blackened, betadine<br>and recliner and we<br>12/19/14- "Blister of<br>blister, dry, no infect<br>1/5/15-"Left outer h<br>1/12/15- "Left heel s<br>infection, betadine to<br>During interview on<br>stated R49 had deed<br>wearing his shoes i<br>R49 liked to sit in his<br>instructed to ensure<br>should not be wear<br>wearing gel boots. | o monitor per wound nurse,<br>ogress Notes from 11/1/14 to<br>ark blister type area on left out<br>, air dry, no complaints of<br>a is 5 cm long x 2 cm wide,<br>derma protector."<br>er heel area intact purplish<br>bational therapy (OT) aware<br>e with derma save heel guards<br>ed. OT looked at area and said<br>bad heels when in bed and<br>ut on resident's care plan and<br>look at on Wednesday."<br>to heel, skin intact."<br>heel remains intact, fluid filled,<br>d and off loaded with use of<br>I site dry and intact,<br>e applied, off loading in bed<br>earing derma saver."<br>n right heel gone left out heel<br>ction, drainage, redness."<br>eel site unchanged."<br>site crusted and dry, no | F3                  | 14 |   |                          |                                     |

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|                          |  | AND HUMAN SERVICES   |                     |    |  | FORM                          | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|----|--|-------------------------------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |    | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245581   | B. WING             |    |  | 01/-                          | 16/2015                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                     |    | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FAIR OA                  | KS LODGE   |  |                     |    | 01 SHADY LANE DRIVE<br>VADENA, MN 56482  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | x  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 314                    | family member (FM<br>tissue injury on his<br>with his shoes on in<br>During interview on<br>stated R49 was to b<br>his feet, should hav<br>over the foot rest of<br>NA-E stated this is<br>remember to do it."<br>During a follow up i<br>a.m. NA-E confirme<br>AFO brace to his rig<br>in his wheelchair. F<br>wearing the AFO br<br>where the brace wa<br>During interview on<br>physical therapist a<br>was to wear a AFO<br>stated, "I am not su<br>PTA-A stated there<br>the AFO brace, so n<br>it on.<br>During interview on<br>registered nurse (R<br>shoes should be off<br>should have gel boo<br>the AFO brace.<br>During interview on<br>of nursing (DON) co<br>for R49 instructed s<br>brace to his right fo<br>the heel and while i | 1)-F stated R49 got the deep<br>heel from crossing his feet<br>in the recliner.<br>1/14/15, at 2:00 p.m. NA-E<br>be wearing derma savers on<br>ve his shoes off with his heels<br>f recliner and off load heels.<br>completed for R49, "When I<br>nterview on 1/15/15, at 10:36<br>ed R49 was to be wearing a<br>ght foot for transfers and while<br>R49 stated R49 had not been<br>race and she was not aware | F 3                 | 14 |  |                               |                                     |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     |  | FOR    | M APPROVED<br>0. 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|--------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     | LE CONSTRUCTION  | (X3) D | ATE SURVEY<br>OMPLETED     |
|                          |   | 245581   | B. WING            |     |  | C      | 1/16/2015                  |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |        |                            |
| FAIR OA                  | KS LODGE  |  |                    |     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482  |        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE  | (X5)<br>COMPLETION<br>DATE |
| F 314                    | Continued From pa   | ge 38  | F3                 | 314 |  |        |                            |
|                          | the resident had dia<br>healing hip fracture<br>amputee, congestiv<br>chronic kidney dise<br>the resident had no          | DS dated 12/16/14, identified<br>agnoses including depression,<br>, right arm below the elbow<br>ve heart failure, fatigue, and<br>ase. The MDS also identified<br>cognitive impairment and<br>assistance for all areas of<br>ating.         |                    |     |  |        |                            |
|                          | 12/10/14, identified  | rance Collection Sheet dated<br>R102 was able to be seated<br>nd lay in bed for 2 hours<br>bony prominence's.  |                    |     |  |        |                            |
|                          | the resident had a r<br>related to decrease<br>instructed to turn ar<br>hours and as neede<br>benefits to the resid       | e plan dated 12/8/14, identified<br>isk for skin break down<br>d mobility, and staff was<br>nd reposition R102 every 2<br>ed, and to explain risks and<br>lent of allowing staff to assist<br>ntinent clothing and brief, and<br>t clothing. |                    |     |  |        |                            |
|                          | R102 was not repos<br>hours on 1/14/2015  | sitioned for greater than 4  |                    |     |  |        |                            |
|                          | 1/14/2015, the follo<br>7:11 a.m. R102 was<br>wheel chair.<br>7:49 a.m. R102 re<br>the dining room.<br>8:17 a.m. R102 was | observation of R102 on<br>wing was observed:<br>s seated in the hallway in a<br>mained in his wheelchair in<br>s brought to the television<br>I in his wheelchair without  |                    |     |  |        |                            |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |  | FORM                          | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245581  | B. WING            |     |  | 01/                           | 16/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FAIR OA                  | KS LODGE   |   |                    |     | 201 SHADY LANE DRIVE<br>NADENA, MN 56482   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 314                    | the wheelchair and<br>8:57 a.m. R102 was<br>room for an activity<br>wheelchair.<br>9:09 a.m. R102 rem<br>wheel chair.<br>10:25 a.m. R102 rem<br>wheelchair and had<br>10:48 a.m. NA-D pu<br>by the nurses statio<br>R102 had not been<br>During interview on<br>stated the nursing a<br>assignments to card<br>stated it was, "Just<br>During a follow up in<br>10:42 a.m. NA-E stat<br>cares on a time sch<br>R102 was on a repo<br>stated R102 was of<br>morning. NA-E stat<br>had been reposition<br>During interview on<br>NA-D stated R102 was<br>stand and/ or be rep<br>R102 was not on a<br>During interview on<br>NA-F stated R102 of<br>repositioning plan, b<br>him to the bathroom | hained in the television area in<br>had not been repositioned.<br>Is brought to the edge of the<br>and remained in the<br>hained in the activity in his<br>emained seated in the<br>not been repositioned.<br>Ushed R102 to the dining area<br>in and provided R102 a snack.<br>repositioned since 7:11 a.m.<br>1/14/15, at 10:32 a.m. NA-E<br>assistants did not have<br>e for specific residents, and<br>free for all."<br>Interview on 01/14/2015, at<br>ated staff did not provide<br>hedule, and she was not aware<br>ositioning schedule. NA-E<br>ten in his wheel chair all<br>ted she was not aware if R102<br>hed that morning.<br>1/14/2015, at 10:51 a.m.<br>would tell staff if he needed to<br>positioned, and she believed<br>repositioning schedule.<br>1/14/2015, at 11:06 a.m.<br>did not have a scheduled<br>but staff would usually take<br>in in the morning around 10:00-<br>ted she had not assisted R102 | F3                 | 314 |  |                               |                                     |

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|                          |  | AND HUMAN SERVICES  |                    |     |  | FORM      | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245581  | B. WING            |     |  | 01/-      | 16/2015                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                    |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FAIR OA                  | KS LODGE   |   |                    |     | 01 SHADY LANE DRIVE<br>VADENA, MN 56482  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 314                    | During interview on<br>stated R102's currer<br>required extensive a<br>and instructed staff<br>every two hours.<br>During observation<br>RN-B and NA-F we<br>toileting. NA-B and<br>and transfer to the t<br>buttocks was intact<br>During interview on<br>RN-B stated R102 or<br>repositioned every a<br>assistant care shee<br>used to provide car<br>instruct staff to turn<br>hours to prevent sk<br>During interview on<br>DON stated R102 s<br>and/or repositioned<br>resident should not<br>without toileting/rep<br>The facility policy tit<br>Integrity/Wound Ma<br>9/13/2011, identified<br>Residents with risk<br>integrity will receive<br>treatment/services,<br>determined to be at<br>skin integrity, will re<br>treatment/services | <ul> <li>1/14/2015, 11:13 a.m. RN-B<br/>ent care plan indicated R102<br/>assistance with repositioning,<br/>to reposition the resident</li> <li>on 1/14/2015, at 11:22 a.m.<br/>asked to assist R102 with<br/>INA-F assisted R102 to stand<br/>toilet. R102's skin on his<br/>, but wrinkled and creased.</li> <li>1/16/2015, at 10:11 a.m.<br/>was assessed to be<br/>2 hrs, however, the nursing<br/>et (identified as what the NAs<br/>es to residents) did not<br/>and reposition every two<br/>in breakdown.</li> <li>1/16/2015, at 11:31 a.m. the<br/>should have been toileted<br/>every 2 hours, and stated the<br/>have gone over 4 hours<br/>positioning.</li> <li>ted Pressure Ulcers/Skin<br/>anagement-HDGR dated<br/>d Treatment/ Management;<br/>for or who have a loss of skin</li> </ul> | F 3                | :14 |  |           |                                     |

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|                          |   | AND HUMAN SERVICES   |                    |          | FOF  | ED: 02/20/2015<br>MAPPROVED<br>O. 0938-0391 |
|--------------------------|---|--|--------------------|----------|--|---|
|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · · /              |          |  | ATE SURVEY<br>OMPLETED                      |
|                          |   | 245581   | B. WING            |          |  | 1/16/2015                                   |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                    |          | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |
| FAIR OA                  | KS LODGE  |  |                    |          | 01 SHADY LANE DRIVE<br>/ADENA, MN 56482  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE                  |
| F 315<br>F 315<br>SS=D   | Continued From pa<br>483.25(d) NO CATH<br>RESTORE BLADD   | HETER, PREVENT UTI,  | F3<br>F3           | 15<br>15 |  | 2/16/15                                     |
|                          | resident who enters<br>indwelling catheter<br>resident's clinical co<br>catheterization was<br>who is incontinent of<br>treatment and servi   | cility must ensure that a<br>s the facility without an<br>is not catheterized unless the<br>ondition demonstrates that<br>necessary; and a resident<br>of bladder receives appropriate<br>ices to prevent urinary tract<br>store as much normal bladder<br>e.  |                    |          |  |   |
|                          | by:<br>Based observation<br>review, the facility for<br>residents (R102) in<br>assistance received<br>toileting.<br>Findings include:<br>R102's diagnoses i<br>right arm below the<br>kidney disease. R1<br>Set (MDS) dated 12<br>cognitively intact. H<br>1/13/2015, at 9:55 a<br>not sure if he had e<br>already been observas<br>was also unaware to<br>home. The quarterl<br>required extensive<br>current care plan da<br>identified he required | NT is not met as evidenced<br>i, interview, and document<br>ailed to ensure that 1 of 1<br>the sample requiring<br>d timely assistance with<br>ncluded healing hip fracture,<br>elbow amputee, and chronic<br>02's quarterly Minimum Data<br>2/16/14, identified R102 was<br>lowever, during an interview on<br>a.m. R102 identified he was<br>eaten this morning and he had<br>ved to eat breakfast. R102<br>that he lived in a nursing<br>y MDS also identified R102<br>assistance for toileting. R102's<br>ated to be revised 12/8/14,<br>ed toileting every two hours<br>02 was to be checked and<br>incontinent |                    |          | Resident #102 had B&B completed, car<br>plan has been reviewed and updated,<br>resident has been assessed per the RN<br>and has had no negative outcomes<br>related the deficient practice.<br>All residents needing assistance with<br>toileting maybe affected by this deficit<br>practice.<br>All residents care plans have been<br>reviewed and updated regarding toileting<br>and repositioning.<br>All residents are assessed for individual<br>B&B plans, and appropriate intervention<br>Nursing staff have been educated on<br>following resident's plan of care, individu<br>toileting and repositioning plans.<br>LN will update care plans and NAR grou<br>assignment's PRN related to individual<br>toileting and repositioning schedules.<br>DON/Designee will complete<br>observational audits weekly on various<br>shifts x 3 months to assure NAR's are | g<br>s.<br>al                               |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |    |  | FORM  | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|---------------------|----|--|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |    |  | (X3) DATE   | E SURVEY<br>PLETED                  |
|                          |   | 245581  | B. WING             |    |  | <b>01</b> / <sup>-</sup>                                  | 16/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                     | ST | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |                                     |
| FAIR OA                  | KS LODGE  |   |                     |    | 01 SHADY LANE DRIVE<br>/ADENA, MN 56482  |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | ×  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 315                    | Continued From pa<br>During intermittent of<br>from 7:11 a.m. and<br>observation from 9:<br>R102 had not been<br>observation on 1/14<br>assisted to toilet. R'<br>stool, with a small a<br>stool on his bottom<br>During interview on<br>indicated the nursin<br>assignments to care<br>stated, "We just free<br>During a second int<br>a.m. NA-E identified<br>a time schedule. NA<br>would tell staff if he<br>bathroom. NA-E ver<br>R102 to be in his will<br>verified that she had<br>toilet so far that mo<br>During an interview<br>NA-D indicated R10<br>to go to the bathroo<br>believed R102 was<br>verified that she had<br>morning.<br>During interview on<br>indicated R102 did | ge 42<br>observations on 1/14/2015,<br>9:09 a.m. and continuous<br>13 a.m. through 10:48 a.m.<br>assisted with toileting. During<br>/15, at 11:22 a.m. R102 was<br>102 had been incontinent of<br>mount of soft non formed<br>and in the incontinence brief.<br>1/14/15, at 10:32 a.m. NA-E<br>g assistants did not have<br>e for specific residents. NA-E<br>te for all it."<br>erview on 1/14/15, at 10:42<br>d staff do not provide cares on<br>A-E further identified R102<br>needed to go to the<br>rified it was not unusual for<br>heelchair all morning. NA-E<br>d not assisted R102 to the | F 3                 | 15 |  | care<br>tion<br>s, to<br>an<br>g.<br>ed at<br>r<br>ected. |                                     |
|                          | and bladder, and at<br>go to the bathroom<br>NA-F indicated R10   | times knew if he needed to<br>or if he had been incontinent.<br>2 would usually be taken to<br>morning. NA-F verified she   |                     |    |  |   |                                     |

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|                          |  | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                     |  | FORM                          | 02/20/2015<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|--|-------------------------------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245581  | B. WING             |  | 01/                           | 16/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER   | •   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FAIR OA                  | KS LODGE   |   |                     | 201 SHADY LANE DRIVE<br>NADENA, MN 56482   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 315                    | During an interview<br>licensed practical n<br>nursing assistants p<br>according to the nu<br>identified she believ<br>bowel and bladder<br>assistance with toile<br>During an interview<br>registered nurse (R<br>assessed to be toil<br>the care plan. How<br>assistant care sheet<br>missed." RN-B veri<br>sheets had been re<br>toileting every two h<br>During an interview<br>director of nursing<br>expect residents care | y on 1/14/15, at 11:10 a.m.<br>hurse (LPN)-B verified the<br>provide care for the residents<br>irsing assistant sheets. LPN-B<br>ved R102 was continent of<br>and he would ask for<br>eting.<br>y on 1/16/2015, at 10:11 a.m.<br>RN)-B verified R102 was<br>leted every 2 hrs and it was on<br>ever, it was not on the nursing<br>et, "and that is why it was<br>ified the nursing assistant care<br>evised to reflect the need for | F 315               |  |                               |                                     |

Facility ID: 00679

If continuation sheet Page 44 of 44

|                          |   | AND HUMAN SERVICES  |                    | F5581023  | FORM     | : 02/19/2015<br>APPROVED<br>. 0938-0391 |
|--------------------------|---|---|--------------------|---|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    | TIPLE CONSTRUCTION<br>ING 01 - DINING ADDITION 01 |          | TE SURVEY<br>MPLETED                    |
|                          |   | 245581  | B. WING            |   | 02       | /06/2015                                |
| NAME OF I                | PROVIDER OR SUPPLIER  | 2   |                    | STREET ADDRESS, CITY, STATE, ZIP COD              | E        |   |
| FAIR OA                  | KS LODGE  | 4   |                    | 201 SHADY LANE DRIVE<br>WADENA, MN 56482          |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |   | HOULD BE | (X5)<br>COMPLETION<br>DATE              |
| K 000                    | INITIAL COMMEN  | TS A  | кс                 | 000   |          |   |
|                          | FIRE SAFETY   |   |                    |   |          |   |
|                          | 01 Main Building  |   |                    |   |          |   |
|                          | ALLEGATION OF O<br>DEPARTMENT'S A<br>SIGNATURE AT TH  | OC WILL SERVE AS YOUR<br>COMPLIANCE UPON THE<br>CCEPTANCE. YOUR<br>HE BOTTOM OF THE FIRST<br>IS-2567 WILL BE USED AS<br>COMPLIANCE.   |                    |   |          |   |
|                          | ONSITE REVISIT O<br>CONDUCTED TO<br>SUBSTANTIAL CO<br>REGULATIONS HA  | OF AN ACCEPTABLE POC, AN<br>OF YOUR FACILITY MAY BE<br>VALIDATE THAT<br>MPLIANCE WITH THE<br>AS BEEN ATTAINED IN<br>ITH YOUR VERIFICATION.  |                    |   |          |   |
|                          | Minnesota Departm<br>time of this survey<br>Building was found<br>with the requiremen<br>Medicare/Medicaid<br>483.70(a), Life Safe<br>edition of National I | Survey was conducted by the<br>nent of Public Safety. At the<br>Fair Oaks Lodge 01 Main<br>not in substantial compliance<br>hts for participation in<br>at 42 CFR, Subpart<br>ety from Fire, and the 2000<br>Fire Protection Association<br>01, Life Safety Code (LSC),<br>g Health Care. | ~                  | EPO   |          |   |
|                          | PLEASE RETURN<br>CORRECTION FO<br>DEFICIENCIES (K   | R THE FIRE SAFETY   |                    |   |          |   |
|                          | Health Care Fire In<br>State Fire Marshal<br>445 Minnesota Stre<br>St. Paul, MN 55101   | Division<br>eet, Suite 145  |                    |   |          |   |
| LABORATOR                | Y DIRECTOR'S OR PROVID  | DER/SUPPLIER REPRESENTATIVE'S SIG   | NATURE             | TITLE   |          | (X6) DATE                               |
| Electron                 | ically Signed   |   |                    |   |          | 02/16/2015                              |

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.

| the second second second second |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |    |  | FORM | 02/19/2015<br>APPROVED<br>0938-0391 |
|---------------------------------|---|---|---------------------|----|--|------|-------------------------------------|
| STATEMENT                       | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |    | E CONSTRUCTION<br>01 - DINING ADDITION 01  |      | e survey<br>IPleted                 |
|                                 |   | 245581  | B. WING _           |    |  | 02/  | 06/2015                             |
| NAME OF F                       | PROVIDER OR SUPPLIER  |   |                     |    |  |      |                                     |
| FAIR OAI                        | KS LODGE  |   |                     |    | 1 SHADY LANE DRIVE<br>ADENA, MN 56482  |      |                                     |
| (X4) ID<br>PREFIX<br>TAG        | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | :  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE | (X5)<br>COMPLETION<br>DATE          |
| K 000                           | Continued From pa   | ge 1  | K 00                | 00 |  |      | a)                                  |
|                                 | DEFICIENCY MUS<br>FOLLOWING INFO<br>1. A description of v<br>to correct the deficie   | n@state.mn.us<br>RRECTION FOR EACH<br>T INCLUDE ALL OF THE<br>PRMATION:<br>vhat has been, or will be, done  |                     |    |  |      |                                     |
| -                               | The facility was sur  | ection and monitoring to<br>nce of the deficiency<br>veyed as 2 buildings.  |                     |    |  |      |                                     |
|                                 | times. In 1995 the k<br>was constructed to<br>and is a 2-story add<br>be of Type IV(2HH)<br>with a 10 foot enclose<br>barrier. No sleeping<br>The original building<br>constructed in 1965<br>Type II (222) constru-<br>system that meets to<br>Sec 19.1.6.2. In 197<br>constructed to the e<br>is 3-story building, r<br>determined to be of<br>and has a wood roo | as constructed at four different<br>itchen and dining building 02<br>the west of the 1965 building<br>ition that was determined to<br>construction. It is separated<br>sed walkway and a 2-hour fire<br>rooms are in this building.<br>(02 Main Building) was<br>, was determined to be of<br>uction and has a wood roof<br>he exception to NFPA 101<br>72 a 3-story addition was<br>east of the original building that<br>to basement and was<br>Type II (222) construction<br>f system that meets the<br>101 Sec 19.1.6.2. In 1976, a |                     |    |  |      |                                     |

Facility ID: 00679

If continuation sheet Page 2 of 4

PRINTED: 02/19/2015 FORM APPROVED OMB NO. 0938-0391

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

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION<br>IG 01 - DINING ADDITION 01  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|---|---------------------|---|-------------------------------|
|                          |   | 245581  | B. WING             |   | 02/06/2015                    |
|                          | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>201 SHADY LANE DRIVE<br>WADENA, MN 56482                       |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETIO              |
| K 000<br>K 052<br>SS=D   | 2-story addition wa<br>was determined to<br>construction.<br>The facility is comp<br>a dry pipe system a<br>1995 addition). The<br>in the corridor syste<br>corridor, in all comp<br>rooms that are on to<br>that has automatic<br>The facility has a ca<br>census of 68 at the<br>NFPA 101 LIFE SA<br>A fire alarm system<br>installed, tested, an<br>with NFPA 70 Natio<br>72. The system has | s constructed to the south that<br>be of Type II(222)<br>eletely sprinkler protected with<br>and a wet pipe system (in the<br>e facility has smoke detection<br>em, in all areas open to the<br>mon areas and in all sleeping<br>he facility's fire alarm system<br>fire department notification.<br>apacity of 75 beds and had a<br>time of the survey.<br>42 CFR, Subpart 483.70(a) is<br>need by:<br>FETY CODE STANDARD<br>required for life safety is<br>ad maintained in accordance<br>onal Electrical Code and NFPA<br>s an approved maintenance<br>n complying with applicable | K 00                |   | 2/16/15                       |
|                          | Based on observat   | s not met as evidenced by:<br>tion and staff interview, the<br>all and maintain the fire alarm  |                     | Director of Maintenance/Design<br>have smoke detectors installed  | iee will<br>to be             |

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |   | FORM | 02/19/2015<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|---|------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION<br>01 - DINING ADDITION 01   |      | E SURVEY<br>PLETED                  |
|                          |   | 245581  | B. WING            |     |   | 02/0 | 06/2015                             |
| NAME OF F                | ROVIDER OR SUPPLIER   |   |                    |     | TREET ADDRESS, CITY, STATE, ZIP CODE  |      |                                     |
| FAIR OAI                 | KS LODGE  |   |                    | _   | 01 SHADY LANE DRIVE<br>VADENA, MN 56482   |      |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE          |
| K 052                    | system in accordan<br>2000 NFPA 101, Se<br>well as 1999 NFPA<br>2-3.5.1. These defi<br>adversely affect the<br>system that could d<br>emergency actions | ge 3<br>ice with the requirements of<br>ections 19.3.4.1 and 9.6, as<br>72, Sections 2-3.4.5.1.2,<br>icient practices could<br>e functioning of the fire alarm<br>lelay the timely notification and<br>for the facility thus negatively<br>staff, and visitors of the | K                  | )52 | more than 36 inches from HVAC di<br>Corrective Action is to be complete<br>2/25/15                                |      |                                     |
|                          | 02/06/2015, observ<br>smoke detectors loo<br>leading to the kitche<br>lower level were ins<br>HVAC diffusers.   | veen 8:00 AM on 11:00 AM on<br>ations revealed that the<br>cated in the ramp corridor<br>en and by the east exit of the<br>stalled within 36 inches of<br>ice was verified by the Director  |                    |     |   |      |                                     |
|                          |   |   |                    |     |   |      |                                     |

Event ID: QMWJ21

Facility ID: 00679

If continuation sheet Page 4 of 4

|                          |  | AND HUMAN SERVICES   |                    | FOR FOR                               | D: 02/19/2015<br>M APPROVED<br>O. 0938-0391 |
|--------------------------|--|--|--------------------|---------------------------------------|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |                                       | ATE SURVEY<br>OMPLETED                      |
|                          |  | 245581   | B. WING            | 30                                    | 2/06/2015                                   |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE |   |
|                          | KS LODGE   |  |                    | 201 SHADY LANE DRIVE                  |   |
|                          |  |  |                    | WADENA, MN 56482                      | 0(5)  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | FIX (EACH CORRECTIVE ACTION SHOULD BE | (X5)<br>COMPLETION<br>DATE                  |
| K 000                    | INITIAL COMMEN   | TS   | кc                 | 000                                   |   |
|                          | FIRE SAFETY  |  |                    |                                       |   |
|                          | 02 Kitchen and Din   | ing Addition   |                    |                                       |   |
|                          | Minnesota Departn<br>time of this survey<br>Kitchen/Dining Buil<br>compliance with the<br>in Medicare/Medica<br>483.70(a), Life Safe<br>edition of National  | Survey was conducted by the<br>nent of Public Safety. At the<br>Fair Oaks Lodge 02<br>ding was found in substantial<br>e requirements for participation<br>aid at 42 CFR, Subpart<br>ety from Fire, and the 2000<br>Fire Protection Association<br>01, Life Safety Code (LSC),<br>g Health Care.   |                    |                                       |   |
|                          | Fair Oaks Lodge w<br>times. In 1995 the<br>was constructed to<br>and is a 2-story ad<br>be of Type IV(2HH<br>with a 10 foot enclo<br>barrier. No sleepin<br>The original buildin<br>constructed in 196<br>Type II (222) const<br>system that meets<br>Sec 19.1.6.2. In 19<br>constructed to the<br>is 3-story building,<br>determined to be co<br>and has a wood ro<br>exception to NFPA | rveyed as 2 buildings.<br>vas constructed at four different<br>kitchen and dining building 02<br>the west of the 1965 building<br>dition that was determined to<br>) construction. It is separated<br>osed walkway and a 2-hour fire<br>g rooms are in this building.<br>tg (02 Main Building) was<br>5, was determined to be of<br>ruction and has a wood roof<br>the exception to NFPA 101<br>072 a 3-story addition was<br>east of the original building that<br>no basement and was<br>of Type II (222) construction<br>of system that meets the<br>101 Sec 19.1.6.2. In 1976, a<br>as constructed to the south that<br>be of Type II(222) | ~                  | EPOC                                  |   |
|                          | Y DIRECTOR'S OR PROVI  | DER/SUPPLIER REPRESENTATIVE'S SIG  | NATURE             | TITLE                                 | (X6) DATE                                   |
|                          | nically Signed   |  |                    |                                       | 02/16/2015                                  |

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.

|                          |   | AND HUMAN SERVICES  |                     |   | FORM           | ): 02/19/2015<br>APPROVED<br>): 0938-0391 |
|--------------------------|---|---|---------------------|---|----------------|---|
| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION<br>IG 02 - MAIN BUILDING 02   | (X3) DA<br>COI | TE SURVEY<br>MPLETED                      |
|                          |   | 245581  | B. WING             |   | 02             | /06/2015                                  |
|                          | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>201 SHADY LANE DRIVE<br>WADENA, MN 56482                       |                |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE         | (X5)<br>COMPLETION<br>DATE                |
| K 000                    | a dry pipe system a<br>1995 addition). The<br>in the corridor syste<br>corridor, in all com<br>rooms that are on a<br>that has automatic<br>The facility has a c<br>census of 68 at the | age 1<br>Detely sprinkler protected with<br>and a wet pipe system (in the<br>e facility has smoke detection<br>em, in all areas open to the<br>mon areas and in all sleeping<br>the facility's fire alarm system<br>fire department notification.<br>apacity of 75 beds and had a<br>e time of the survey.<br>t 42 CFR, Subpart 483.70(a) | K 00                |   |                |   |
|                          |   |   |                     |   |                |   |

Event ID: QMWJ21

Facility ID: 00679

If continuation sheet Page 2 of 2



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted February 6, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5581024

Dear Mr. Blanchard:

The above facility was surveyed on January 12, 2015 through January 16, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number . that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

Fair Oaks Lodge February 6, 2015 Page 2

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact **Pam Kerssen at (218) 308-2129 or email: pam.kerssen@state.mn.us.** 

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

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

Sincerely,

mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

5581s15lic

| Minneso                  | ta Department of He   | alth   |                       |   |   |                          |
|--------------------------|---|--|-----------------------|---|---|--------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                   |   | (X3) DATE<br>COMP                       | SURVEY<br>LETED          |
|                          |   | 00679  | B. WING               |   | 01/1                                    | 6/2015                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S        | STATE, ZIP CODE   |   |                          |
| FAIR OA                  | KS LODGE  |  | Y LANE DR<br>MN 56482 | IVE   |   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | D BE                                    | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Initial Comments  |  | 2 000                 |   |   |                          |
|                          | *****ATTEI  | NTION*****   |                       |   |   |                          |
|                          | NH LICENSING  | CORRECTION ORDER   |                       |   |   |                          |
|                          | 144A.10, this correct<br>pursuant to a surver<br>found that the defic<br>herein are not correct<br>not corrected shall<br>with a schedule of f<br>the Minnesota Depa<br>Determination of wh<br>corrected requires of<br>requirements of the<br>number and MN Ru<br>When a rule contain<br>comply with any of<br>lack of compliance.<br>re-inspection with a<br>result in the assess | nether a violation has been  |                       |   |   |                          |
|                          | that may result from<br>orders provided tha<br>the Department with  | hearing on any assessments<br>n non-compliance with these<br>t a written request is made to<br>nin 15 days of receipt of a<br>nt for non-compliance.   |                       |   |   |                          |
|                          | Department's staff,<br>the following licensi<br>corrections are com<br>make a copy of the<br>original to the Minne<br>Division of Complia   | "S:<br>1/16/15, surveyors of this<br>visited the above provider and<br>ng orders were issued. When<br>ppleted, please sign and date,<br>se orders and return the<br>esota Department of Health,<br>nce Monitoring, Licensing and |                       | The facility has agreed to participa<br>electronic receipt of State licensure<br>consistent with the Minnesota Dep<br>of Health Informational Bulletin 14-<br>available at<br>http://www.health.state.mn.us/divs<br>info/infobul.htm The State licensin | e orders<br>artment<br>01,<br>/fpc/prof |                          |
| ABORATOR                 | epartment of Health<br>Y DIRECTOR'S OR PROVIE<br>ically Signed  | ER/SUPPLIER REPRESENTATIVE'S SIGN  | NATURE                | TITLE   |   | (X6) DATE<br>02/16/15    |

Electronically Signed

6899

If continuation sheet 1 of 50

| STATEMEN                 | ta Department of He  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                          | LE CONSTRUCTION  | (X3) DATE<br>COMPI  |                         |
|--------------------------|--|---|--------------------------|--|---|-------------------------|
|                          |  | 00679   | B. WING                  |  | 01/16/2015  |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY,             | STATE, ZIP CODE  |   |                         |
| FAIR OA                  | KS LODGE   |   | )Y LANE DR<br>, MN 56482 |  |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                     | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)  | D BE  | (X5)<br>COMPLET<br>DATE |
| 2 000                    | Continued From pa  | ge 1  | 2 000                    |  |   |                         |
|                          | Certification Progra<br>Suite 300, Fergus F  | m; 1505 Pebble Lake Rd,<br>Falls, MN 56537.   |                          | orders are delineated on the attack<br>Minnesota Department of Health of<br>being submitted electronically. Alt<br>no plan of correction is necessary<br>State Statutes/Rules, please enter<br>word "corrected" in the box availab<br>text. Then indicate in the electronic<br>licensure process, under the head<br>completion date, the date your ord<br>be corrected prior to electronically<br>submitting to the Minnesota Depar<br>Health. | rders<br>hough<br>for<br>the<br>ble for<br>c State<br>ing<br>ers will |                         |
| 2 302                    | MN State Statute 14 or related disorder t  | 44.6503 Alzheimer's disease<br>rain   | 2 302                    |  |   | 2/16/15                 |
|                          | ALZHEIMER'S DIS<br>DISORDER TRAIN<br>MN St. Statute 144.   |   |                          |  |   |                         |
|                          | Alzheimer's<br>disease or related or<br>segregated or gene<br>care staff   | ity serves persons with<br>lisorders, whether in a<br>ral unit, the facility's direct<br>rs must be trained in dementia |                          |  |   |                         |
|                          | <ul> <li>related disorders;</li> <li>(2) assistance with</li> <li>(3) problem solving<br/>and</li> <li>(4) communication</li> <li>(c) The facility shall<br/>written or electronic<br/>training program, th</li> </ul> | of Alzheimer's disease and activities of daily living; with challenging behaviors;                                      |                          |  |   |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |   | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>01/16/2015 |                        |
|--------------------------|---|--|---|--|---|------------------------|
|                          |   | 00679  | B. WING                                   |  |   |                        |
|                          | PROVIDER OR SUPPLIER<br><b>KS LODGE</b>   | 201 SHA  | DRESS, CITY,<br>DY LANE DR<br>A, MN 56482 |  |   |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE  | (X5)<br>COMPLE<br>DATE |
| 2 302                    | topics covered.<br>(d) The facility shall<br>this section.<br>This MN Requireme<br>by:  | document compliance with<br>ent is not met as evidenced  | 2 302                                     |  |   |                        |
|                          | Based on interview<br>facility failed to ensu-<br>information for care<br>disease and demer<br>form. In addition, th<br>description of the tr<br>of employees traine<br>and the basic topics<br>The facility's curren<br>reviewed, which inc<br>provided and multip<br>resident upon admi | and document review, the<br>ure consumers were provided<br>of residents with Alzheimer's<br>natia in a written or electronic<br>ne facility failed to identify a<br>aining program, the categories<br>ed, the frequency of training<br>is covered in the training.<br>It admission packet was<br>cluded facility services<br>ole documents given to a new<br>ssion. The admission packet<br>rmation regarding the<br>e training program. |   | Nursing staff will be trained annually on<br>dementia, including disease process and<br>behaviors of residents, and how to assist<br>with ADL's and communication<br>techniques.<br>SW/Designee will hold Family Council<br>meetings at least bi-annually, and inform<br>residents families by placing a letter in the<br>admission packets. |   |                        |
|                          | administrator confir<br>informed their cons<br>training information<br>SUGGESTED MET  | 1/16/15, at 12:54 p.m. the<br>med the facility had not<br>umers of the Alzheimer's<br>in written or electronic form.   |   |  |   |                        |
|                          | information regardin<br>and dementia requi<br>admission packet for<br>quality assurance c<br>monitoring system t  | or designee could add<br>ng the Alzheimer's disease<br>rements into the resident<br>or consumer information. The<br>ommittee could design a<br>to ensure compliance.   |   |  |   |                        |
|                          | TIME PERIOD FOF<br>(21) days.   | R CORRECTION: Twenty-one   |   |  |   |                        |

| IAME OF PROVI   | ND PLAN OF CORRECTION II  | ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA<br>N OF CORRECTION IDENTIFICATION NUMBER:   |                       | ·  | (X3) DATE SURVEY<br>COMPLETED                |                         |
|---|---|---|-----------------------|--|--|-------------------------|
| IAME OF PROVI   |   | 00679   | B. WING               |  | 01/16  | 6/2015                  |
|   | IDER OR SUPPLIER  | STREET ADD  | DRESS, CITY,          | STATE, ZIP CODE  |  |                         |
| AIR OAKS L  | ODGE  |   | Y LANE DR<br>MN 56482 | IVE  |  |                         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   |  | (X5)<br>COMPLET<br>DATE |
| 2 560 Con   | ntinued From pag  | ge 3  | 2 560                 |  |  |                         |
|   | Rule 4658.0405<br>n of Care; Conte  | 5 Subp. 2 Comprehensive<br>nts  | 2 560                 |  |  | 2/16/15                 |
| obje<br>long<br>and<br>ider<br>asso<br>requ<br>sub<br>This<br>by:<br>Bas<br>facil<br>plar<br>antio<br>nee<br>med<br>for u<br>Find<br>Rafi<br>Rep<br>othe<br>Rep<br>7.5<br>app<br>well<br>anxi | ectives and time<br>g- and short-term<br>d mental and psy<br>ntified in the com-<br>sessment. The c<br>st include the incu-<br>uired by Minnesc<br>odivision 14, para<br>s MN Requirements<br>sed on interview<br>ility failed to deven<br>in that included the<br>idepressant med<br>dication) for 1 of<br>unnecessary med<br>dication) for 1 of<br>unnecessary med<br>dings include:<br>1 was admitted the<br>gnosis identified<br>port included anxies<br>port also identified<br>mg (milligrams),<br>petite, decrease a<br>I as Ativan 0.5 m<br>ciety or sleep. | ent is not met as evidenced<br>and document review, the<br>elop a comprehensive care<br>ne daily use of Remeron (an<br>lication) and a PRN (as<br>tivan (an antianxiety<br>f 5 residents (R31) reviewed |                       | SW/MDS Coordinator and Nurse<br>Managers will receive education on<br>completing care plans that include<br>incorporating these classes of medic<br>in their care plans.<br>SW/NM will update all care plans to<br>assure the class of medication is incl<br>in current care plans and MDS/SW w<br>develop care plans for all new admis<br>DON/Designee will assure process is<br>completed and will audit care plans v<br>x 3 months to assure system is intac<br>Findings from audits will be reviewed<br>QAA x 3 months to assure trends or<br>negative findings of audits are correc<br>Corrective Action is to be completed<br>by:2/25/15 | uded<br>/ill<br>sions.<br>veekly<br>t.<br>at |                         |

| TATEMEN                  | It OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                         |   |                                   | E SURVEY<br>PLETED      |
|--------------------------|---|--|-----------------------------|---|-----------------------------------|-------------------------|
|                          |   | 00679  |                             | B. WING   |                                   | 16/2015                 |
| IAME OF I                | PROVIDER OR SUPPLIER  | STREET AL  | DRESS, CITY, ST             | TATE, ZIP CODE  |                                   |                         |
| AIR OA                   | KS LODGE  |  | DY LANE DRIV<br>A, MN 56482 | /E  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 560                    | Continued From pa   | age 4  | 2 560                       |   |                                   |                         |
|                          |   | ent system) MDS dated August<br>I a BIMS of 8 indicating<br>ed cognition.  |                             |   |                                   |                         |
|                          | (MAR) for October,<br>2014, and January<br>Ativan twice in Octo<br>four times in Decer<br>(through 1/14/15).  | ication administration records<br>, November and December<br>2015, indicated that R31 took<br>ober, nine times in November,<br>mber and 5 times in January<br>Review of the behavior<br>ses notes identified anxious<br>almost daily.  |                             |   |                                   |                         |
|                          | identified mood/bel<br>behaviors related to<br>poor impulse contro-<br>interventions of mo-<br>needs, monitor ever<br>observed behavior<br>behavior log, monit<br>the situation and al<br>express himself, pr<br>good behavior and<br>aspects of complia<br>agitated intervene l<br>guide away form so<br>calmly in conversat<br>and Ativan were no | an created on 6/27/14,<br>haviors of verbally abusive<br>o ineffective coping skills and<br>ol. Non pharmacological<br>onitor and anticipate resident's<br>ery shift and document<br>and attempted interventions in<br>for resident's understanding of<br>low time for the resident to<br>rovide positive feedback for<br>emphasize the positive<br>nce, when he becomes<br>before agitation escalates,<br>purce of distress, engage<br>tion. The use of the Remeron<br>of addressed on the care plan. |                             |   |                                   |                         |
|                          | 1/14/15, at 2:30 p.r<br>medications were r  | th the director of hursing on<br>n. she verified that the<br>not addressed on the care plan<br>expect them to be.  |                             |   |                                   |                         |
|                          | The director of nurs  | THOD OF CORRECTION:<br>sing or designee could direct<br>are plan to include appropriate  |                             |   |                                   |                         |

| STATEMEN      | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                          |   | ATE SURVEY<br>OMPLETED |
|---------------|---|---|--------------------------|---|------------------------|
|               |   |   | A. BUILDING              | ·   |                        |
|               |   | 00679   | B. WING                  | 1/16/2015   |                        |
| NAME OF I     | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY,             | STATE, ZIP CODE   |                        |
| FAIR OA       | KS LODGE  |   | )Y LANE DR<br>, MN 56482 |   |                        |
| (X4) ID       |   | TEMENT OF DEFICIENCIES  | ID                       | PROVIDER'S PLAN OF CORRECTION   | (X5)<br>COMPLETE       |
| PREFIX<br>TAG |   | ' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG            | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | DATE                   |
| 2 560         | Continued From pa   | ge 5  | 2 560                    |   |                        |
|               | monitoring program to assure ongoing a  | identified care needs. A<br>could be established in order<br>and effective care plan<br>conse to resident care needs.   |                          |   |                        |
|               | TIME PERIOD FOF<br>(21) days  | R CORRECTION: Twenty One  |                          |   |                        |
| 2 565         | MN Rule 4658.0405<br>Plan of Care; Use  | 5 Subp. 3 Comprehensive   | 2 565                    |   | 2/16/15                |
|               |   | omprehensive plan of care<br>personnel involved in the  |                          |   |                        |
|               | by:<br>Based on observati<br>review, the facility fa<br>of care for 2 of 2 re-<br>at risk for pressure<br>(R102) who require  | ent is not met as evidenced<br>on, interview, and document<br>ailed to follow the written plan<br>sidents (R49, R102) reviewed<br>ulcers, for 1 of 2 resident<br>d assistance with toileting,<br>ents (R51) reviewed for<br>ed skin conditions. |                          | Nursing staff will receive education on s<br>care and pressure ulcer prevention<br>including following care guides for turnir<br>schedules and on following residents pla<br>of care, including following their group<br>assignments which they are to carry.<br>Group assignments reveal toileting,<br>repositioning and assistive devices | g                      |
|               | R49's quarterly Min<br>12/1/14, indicated F<br>peripheral vascular<br>cerebrovascular acc<br>hemiplegia. The M<br>cognitively intact, re<br>of 2 staff to physica<br>transfers, dressing,<br>identified at risk for |   |                          | residents require.<br>LN will receive education on following pl<br>of care for residents with bruising.<br>DON/Designee will complete random<br>audits weekly for 3 months to assure<br>deficient practice has been corrected.<br>QAA will review results over next 3 mon<br>to review for trends and any deficient<br>practice.            |                        |

| STATEMEN                 | It a Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                         | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|---|-----------------------------|--|-----------------------------------|-------------------------|
|                          |  | 00679   | B. WING                     |  | 01/                               | 16/2015                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, ST             | ATE, ZIP CODE  |                                   |                         |
| AIR OA                   | KS LODGE   |   | DY LANE DRIV<br>., MN 56482 | Έ  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa  | age 6   | 2 565                       |  |                                   |                         |
|                          | subcutaneous tissu   | a (a pressure related injury to<br>ues under intact skin) and<br>have a pressure relieving<br>bed.  |                             |  |                                   |                         |
|                          | staff to off load (rel<br>and recliner, wear a<br>heel guards on in b<br>inspection, update<br>turn and reposition                     | plan dated 11/24/14, instructed<br>ieve pressure) heels in bed<br>a left heel derma saver, have<br>bed and recliner, weekly skin<br>physician on skin changes,<br>every 4 hours, and to wear<br>p brace) with transfers and<br>ir.  |                             |  |                                   |                         |
|                          | directed staff to use  | are Plan dated 1/15/15,<br>e derma savers to left heel<br>d bed and off load heels with   |                             |  |                                   |                         |
|                          | at 7:05 a.m. nursing<br>were getting R49 d<br>his recliner. After F<br>proceeded to assis<br>his wheelchair. R49<br>tennis shoes on bo | of morning cares on 1/14/15,<br>g assistant (NA)-E and NA-F<br>ressed while he was sitting in<br>R49's shirt was on, NA-E<br>tt R49 to do a pivot transfer into<br>9 was observed to have black<br>th feet with no AFO brace to<br>was brought out of his room at                         |                             |  |                                   |                         |
|                          | room, and his feet<br>rest of the recliner<br>black tennis shoes<br>resident continued<br>GNP entered his ro<br>black tennis shoes     | vas sitting in his recliner in his<br>were elevated up on the foot<br>and continued to wear his<br>on his feet. At 9:02 a.m. the<br>to sit in his recliner and the<br>oom and proceeded to take the<br>off to look at his left heel GNP<br>plack scab approximately 2 cm<br>pot is good." |                             |  |                                   |                         |
|                          | During observation   | on 1/15/15, at 3:30 p.m. R49  |                             |  |                                   |                         |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            |  |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|---|----------------------------|--|-----------------------------------|-------------------------|
|                          | 00679  |   | B. WING                    |  | 01/16/2015                        |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, ST            | TATE, ZIP CODE   |                                   |                         |
| FAIR OA                  | KS LODGE   |   | OY LANE DRIN<br>, MN 56482 | /E   |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | was sitting in his re<br>on the foot rest of t<br>on, and the derma<br>bed and not on his<br>R49's Tissue Tolera<br>11/25/14, indicated<br>pressure on R49's<br>was to have his left<br>savers on.<br>During interview on<br>stated R49 had dee<br>wearing his shoes if<br>R49 liked to sit in h<br>instructed to ensure<br>should not be wear<br>wearing gel boots.<br>During interview on<br>stated R49 was to h<br>his feet, should hav<br>over the foot rest o<br>NA-E stated this is<br>remember to do it.'<br>During a follow up i<br>a.m. NA-E confirme<br>AFO brace to his ri<br>in his wheelchair. I<br>wearing the AFO b<br>where the brace wa<br>During interview on<br>physical therapist a<br>was to wear a AFO<br>stated, "I am not su<br>PTA-A stated there | cliner, had his feet elevated up<br>he recliner. R49 had no shoes<br>saver boots were laying on his<br>feet.<br>ance Collection Sheet dated<br>skin issues related to<br>left heel, and indicated R49<br>theel off loaded with derma<br>1/14/15, at 8:55 a.m. GNP<br>ep tissue injuries caused by<br>in the recliner. GNP stated<br>is recliner, and staff was<br>e R49 had his heels off loaded,<br>ing shoes, and should be<br>1/14/15, at 2:00 p.m. NA-E<br>be wearing derma savers on<br>ve his shoes off with his heels<br>f recliner and off load heels.<br>completed for R49, "When I<br>interview on 1/15/15, at 10:36<br>ed R49 was to be wearing a<br>ght foot for transfers and while<br>R49 stated R49 had not been<br>race and she was not aware | 2 565                      |  | 51)                               |                         |

| STATEMEN                 | ta Department of He<br>T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |
|--------------------------|---|--|-----------------------------|--|-----------------------------------|-------------------------|
|                          |   | 00679  | B. WING                     |  | 01/16/                            |                         |
| NAME OF F                | PROVIDER OR SUPPLIER  |  | DDRESS, CITY, ST            | TATE, ZIP CODE   |                                   | 10/2010                 |
|                          | KS LODGE  |  | DY LANE DRIV<br>A, MN 56482 | /E   |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | age 8  | 2 565                       |  |                                   |                         |
|                          | During interview on 1/15/15 at 11:20 a.m.<br>registered nurse (RN)-B confirmed that R49's<br>shoes should be off when he is in the recliner,<br>should have gel boots on, and should be wearing<br>the AFO brace.<br>During interview on 1/15/15, at 3:15 p.m. director<br>of nursing (DON) confirmed the current care plan<br>for R49 instructed staff R49 was to have a AFO<br>brace to his right foot during transfer to protect<br>the heel and while in his wheelchair, and was to |  |                             |  |                                   |                         |
|                          | R102 was not assis<br>according to the pla<br>R102's quarterly M<br>the resident had dia<br>healing hip fracture<br>amputee, congestiv<br>chronic kidney dise<br>the resident had no  | DS dated 12/16/14, identified<br>agnoses including depression,<br>e, right arm below the elbow<br>ve heart failure, fatigue, and<br>ease. The MDS also identified<br>o cognitive impairment and<br>assistance for all areas of                 |                             |  |                                   |                         |
|                          | 12/10/14, identified in the wheelchair a  | rance Collection Sheet dated<br>R102 was able to be seated<br>nd lay in bed for 2 hours<br>bony prominence's.  |                             |  |                                   |                         |
|                          | the resident had a related to decrease<br>instructed to turn at<br>hours and as need<br>benefits to the resid   | e plan dated 12/8/14, identified<br>risk for skin break down<br>ed mobility, and staff was<br>nd reposition R102 every 2<br>ed, and to explain risks and<br>dent of allowing staff to assist<br>ntinent clothing and brief, and<br>t clothing. |                             |  |                                   |                         |
|                          | During continuous   | observation of R102 on   |                             |  |                                   |                         |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION   |                                | E SURVEY<br>PLETED       |
|--------------------------|---|---|-----------------------------|--|--------------------------------|--------------------------|
|                          |   | 00679   | 00679 B. WING               |  | 01/                            | 16/2015                  |
| NAME OF                  | ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  |   |                             |  |                                |                          |
| FAIR OA                  | KS LODGE  |   | DY LANE DRIV<br>A, MN 56482 | /E   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 2 565                    | Continued From pa   | ge 9  | 2 565                       |  |                                |                          |
|                          | <ul> <li>7:11 a.m. R102 was wheel chair.</li> <li>7:49 a.m. R102 rethe dining room.</li> <li>8:17 a.m. R102 was room and remained being repositioned.</li> <li>8:54 a.m. R102 remthe wheelchair and 8:57 a.m. R102 was room for an activity wheelchair.</li> <li>9:09 a.m. R102 remwheel chair.</li> <li>9:09 a.m. R102 remwheel chair.</li> <li>10:25 a.m. R102 remwheelchair and had 10:48 a.m. NA-D puby the nurses station R102 had not been</li> <li>During interview on stated the nursing a assignments to care stated it was, "Just</li> <li>During a follow up in 10:42 a.m. NA-E stated R102 was on a reposition of morning. NA-E stated R102 was of morning. NA-E stated R102 was of morning.</li> </ul> | nterview on 01/14/2015, at<br>ated staff did not provide<br>nedule, and she was not aware<br>ositioning schedule. NA-E<br>ten in his wheel chair all<br>ted she was not aware if R102 |                             |  |                                |                          |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED     |                        |  |
|--------------------------|---|---|---|---|-----------------------------------|------------------------|--|
|                          |   | 00679   | B. WING                                 |   | 01/                               | 16/2015                |  |
|                          | PROVIDER OR SUPPLIER  |   | DDRESS, CITY, S                         |   | 01/16/201                         |                        |  |
|                          |   |   | DY LANE DRIV                            |   |                                   |                        |  |
|                          | KS LODGE  | WADEN   | A, MN 56482                             |   |                                   |                        |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |  |
| 2 565                    | Continued From pa   | ge 10   | 2 565                                   |   |                                   |                        |  |
|                          | During observation<br>RN-B and NA-F we<br>toileting. NA-B and<br>and transfer to the<br>buttocks was intact<br>During interview on<br>RN-B stated R102<br>repositioned every<br>assistant care shee<br>used to provide car<br>instruct staff to turn<br>hours to prevent sk<br>During interview on<br>DON stated R102 s<br>every 2 hours, and<br>have gone over 4 h<br>R102 was not provi<br>toileting according to<br>R102's diagnoses in<br>right arm below the<br>kidney disease. R1<br>12/16/14, identified<br>The quarterly MDS<br>extensive assistant<br>care plan dated to the<br>he required toileting<br>needed. R102 was<br>already incontinent | on 1/14/2015, at 11:22 a.m.<br>re asked to assist R102 with<br>I NA-F assisted R102 to stand<br>toilet. R102's skin on his<br>, but wrinkled and creased.<br>1/16/2015, at 10:11 a.m.<br>was assessed to be<br>2 hrs, however, the nursing<br>et (identified as what the NAs<br>es to residents) did not<br>and reposition every two<br>in breakdown.<br>1/16/2015, at 11:31 a.m. the<br>should have been repositioned<br>stated the resident should not<br>ours without repositioning.<br>ded timely assistance with<br>to the plan of care.<br>ncluded healing hip fracture,<br>elbow amputee, and chronic<br>02's quarterly MDS dated<br>R102 was cognitively intact.<br>also identified R102 required<br>ce for toileting. R102's current<br>be revised 12/8/14, identified<br>g every two hours and as<br>to be checked and changed if | ł                                       |   |                                   |                        |  |
|                          | from 7:11 a.m. and<br>observation from 9:<br>R102 had not been<br>observation on 1/14<br>assisted to toilet. R<br>stool, with a small a   | observations on 1/14/2015,<br>9:09 a.m. and continuous<br>:13 a.m. through 10:48 a.m.<br>assisted with toileting. During<br>4/15, at 11:22 a.m. R102 was<br>102 had been incontinent of<br>amount of soft non formed<br>and in the incontinence brief.  |   |   |                                   |                        |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             | CONSTRUCTION   |                | E SURVEY<br>PLETED      |
|--------------------------|---|--|-----------------------------|--|----------------|-------------------------|
|                          |   | 00679  | B. WING                     |  | 01/            | 16/2015                 |
| IAME OF F                | PROVIDER OR SUPPLIER  | STREET AL  | DRESS, CITY, ST             | ATE, ZIP CODE  |                |                         |
|                          | KS LODGE  |  | DY LANE DRIV<br>A, MN 56482 | /E   |                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | ge 11  | 2 565                       |  |                |                         |
|                          | indicated the nursir assignments to car   | During interview on 1/14/15, at 10:32 a.m. NA-E indicated the nursing assistants did not have assignments to care for specific residents. NA-E stated it was, "Just free for all."   |                             |  |                |                         |
|                          | a.m. NA-E identified<br>a time schedule. Na<br>would tell staff if he<br>bathroom. NA-E ve<br>R102 to be in his w   | terview on 1/14/15, at 10:42<br>d staff do not provide cares on<br>A-E further identified R102<br>needed to go to the<br>rified it was not unusual for<br>heelchair all morning. NA-E<br>d not assisted R102 to the<br>rning.          |                             |  |                |                         |
|                          | NA-D indicated R10<br>to go to the bathroo<br>believed R102 was   | on 1/14/15, at 10:51 a.m.<br>D2 would tell staff if he needed<br>om. NA-D identified she<br>not on a toileting plan. NA-D<br>d not toileted R102 so far that   |                             |  |                |                         |
|                          | indicated R102 did<br>plan. NA-F identifie<br>and bladder, and ai<br>go to the bathroom<br>NA-F indicated R10       | 1/14/15, at 11:06 a.m. NA-F<br>not have a scheduled toileting<br>d R102 was continent of bowe<br>t times knew if he needed to<br>or if he had been incontinent.<br>22 would usually be taken to<br>a morning. NA-F verified she<br>02. |                             |  |                |                         |
|                          | RN-B verified R102<br>every 2 hrs and it w<br>it was not on the nu<br>"and that is why it w<br>nursing assistant ca | on 1/16/2015, at 10:11 a.m.<br>was assessed to be toileted<br>vas on the care plan. However,<br>ursing assistant care sheet,<br>vas missed." RN-B verified the<br>are sheets had been revised to<br>toileting every two hours.         |                             |  |                |                         |
|                          | During an interview   | on 1/16/15, at 11:31 a.m. the  |                             |  |                |                         |

| STATEMEN                 | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                          | CONSTRUCTION  |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|--|--------------------------|---|-----------------------------------|-------------------------|
|                          |  | 00679  | B. WING                  |   | 01/16/2                           |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, ST          | TATE, ZIP CODE  |                                   |                         |
| FAIR OA                  | KS LODGE   |  | DY LANE DRI\<br>MN 56482 | /E  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa  | ge 12  | 2 565                    |   |                                   |                         |
|                          |  | rould expect residents care to rected by the resident care plan.   |                          |   |                                   |                         |
|                          | R51's skin condition was not assessed,<br>monitored or documented according to the care<br>plan.<br>The care plan dated, 3/17/10, directed staff to<br>observe skin with routine daily care, and to report<br>to nurse any changes noted, and to observe for<br>bruising as it is a potential side effect of aspirin<br>therapy. The care plan also directed staff to<br>complete weekly skin inspection with<br>documentation of results. |  |                          |   |                                   |                         |
|                          | was cognitively inta<br>all activities of daily<br>R51 had diagnoses   | dated 12/29/14, indicated R51<br>ct and required assistance for<br>living. The MDS indicated<br>which included degenerative<br>a, Parkinson's, diabetes<br>osteoarthritis.   |                          |   |                                   |                         |
|                          | was seated in a wh<br>Observed one large<br>approximately 3 x 3<br>forearm, also obser<br>bruises on resident<br>on resident's left for<br>on the right forearm<br>ago when her arm I<br>bed. R51 stated th<br>hand also happene<br>caused when staff a<br>grab bar next to the<br>her shirt to assist h   | on 1/13/15, at 3:36 p.m. R51<br>eelchair next to the bed.<br>e dark purple bruise,<br>b inches on the resident's right<br>rved 3 smaller dark purple<br>'s left hand and 1 small bruise<br>rearm. R51 stated the bruise<br>n happened a couple of days<br>pumped the grab bar on the<br>e bruises on the left arm and<br>d a couple days ago and were<br>assist her left arm up to the<br>toilet. R51 stated staff grab<br>er left arm up to the toilet and<br>skin in with her clothes. R51 |                          |   |                                   |                         |

|                          | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · ,                 |  | (X3) DATE SURVEY<br>COMPLETED     |                        |  |
|--------------------------|---|---|---------------------|--|-----------------------------------|------------------------|--|
|                          | 00679   |   | B. WING             |  | 01/                               | 01/16/2015             |  |
|                          | PROVIDER OR SUPPLIER  |   |                     |  |                                   | 10/2015                |  |
|                          |   |   | DY LANE DRIV        |  |                                   |                        |  |
| AIR OA                   | KS LODGE  |   | , MN 56482          |  |                                   |                        |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ITEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |  |
| 2 565                    | Continued From pa   | ge 13   | 2 565               |  |                                   |                        |  |
|                          | about the bruises, t<br>had seen the bruise<br>dressed and undres<br>During medical rec<br>was evident to indic   | ord review, no documentation cate R51 had bruises on the  |                     |  |                                   |                        |  |
|                          | was at risk for skin<br>mobility, DM, edem<br>and bladder inconti   | ated 9/29/14, indicated R51<br>breakdown related to limited<br>a, peripheral vascular disease<br>nence. The skin assessment<br>aff to complete weekly skin  |                     |  |                                   |                        |  |
|                          | confirmed she assi-<br>including dressing of<br>R51 has real thin sl<br>careful when movin<br>did not notice any r<br>had black and blue<br>hands. NA-B repor<br>those bruises on R<br>asked if NA-B had<br>nurses, she stated, | 1/14/15, at 9:57 a.m. NA-B<br>sted R51 with daily cares<br>on 1/14/15. NA-B reported<br>kin and staff have to be very<br>ng her arms. NA-B stated she<br>new bruises, but did state R51<br>bruises on both arms and<br>ted the nurses all know about<br>51's arms and hands. When<br>reported the bruises to the<br>no because the resident has<br>ruises on her skin ever since<br>his facility. |                     |  |                                   |                        |  |
|                          | reported R51 bruise<br>confirm if R51 currer<br>reviewing the media<br>she was the nurse<br>stated staff would n<br>documenting bruise<br>resident's bath days<br>progress notes, and   | 1/14/15, at 9:59 a.m. LPN-A<br>es very easily, but could not<br>ently had any bruises without<br>cal record. LPN-A confirmed<br>for R51 on 1/14/15. LPN-A<br>nonitor bruises by<br>es in the progress notes on the<br>s. LPN-A reviewed R51's<br>d LPN-A reported the last<br>imented was on 1/2/15, and  |                     |  |                                   |                        |  |

| STATEMENT                | a Department of He   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             |  |                                   | E SURVEY<br>PLETED      |
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|                          | 00679  |   | B. WING                     | B. WING  |                                   | 16/2015                 |
| NAME OF PF               | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST            | ATE, ZIP CODE  |                                   |                         |
| FAIR OAK                 | S LODGE  |   | DY LANE DRIV<br>A, MN 56482 | E  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
|                          | time. LPN-A stated<br>inspection would ha<br>bath day) and confi<br>assessment docum<br>record related to sk<br>no staff had reporte<br>hands or arms. LP<br>with R51 consistent<br>During interview on<br>DON stated staff ar<br>bruising during daily<br>nurses right away s<br>monitor the bruise i<br>resolved. The DON<br>to follow the care pl<br>documenting results<br>Review of the facilit<br>Plans-Comprehens<br>indicated the care p<br>resident's medical,<br>psychosocial needs<br>comprehensive ass<br>A SUGGESTED ME<br>The director of nurs<br>develop and implen<br>to ensure that resid<br>the plan of care; ed<br>develop monitoring<br>compliance and rep<br>Assurance Commit | rns to body surface at that<br>I R51's last weekly skin<br>ave been on 1/9/15 (R51's<br>rmed that the weekly skin<br>bentation was missing in the<br>in condition. LPN-A confirmed<br>ed R51 having any bruising to<br>N-A stated she does not work<br>tly, and works all three floors.<br>1/14/15, at 12:47 p.m. the<br>re expected to observe for<br>y cares and report bruises to<br>to the nurse can assess and<br>n the progress notes until<br>N confirmed staff are expected<br>an which included<br>s of weekly skin inspections.<br>ty's Care<br>ive policy dated April 1, 2008,<br>plans are designed to meet the<br>nursing, mental and<br>s, as identified in the<br>sessments. |                             |  |                                   |                         |

| Minneso                  | ta Department of He   | alth   |                          |   |   | APPROVE                  |
|--------------------------|---|--|--------------------------|---|---|--------------------------|
|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                          | E CONSTRUCTION  | (X3) DATE<br>COMP   | SURVEY<br>LETED          |
|                          |   | 00679  | B. WING                  |   | 01/1  | 6/2015                   |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,             | STATE, ZIP CODE   |   |                          |
| FAIR OA                  | KS LODGE  |  | OY LANE DR<br>, MN 56482 | IVE   |   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | ) BE  | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | Continued From pa   | ge 15  | 2 830                    |   |   |                          |
| 2 830                    | MN Rule 4658.0520<br>Proper Nursing Car   | ) Subp. 1 Adequate and<br>e; General   | 2 830                    |   |   | 2/16/15                  |
|                          | receive nursing care<br>custodial care, and<br>individual needs an<br>the comprehensive<br>plan of care as des<br>4658.0405. A nursi<br>of bed as much as<br>written order from t   | general. A resident must<br>e and treatment, personal and<br>supervision based on<br>d preferences as identified in<br>resident assessment and<br>scribed in parts 4658.0400 and<br>ng home resident must be out<br>possible unless there is a<br>he attending physician that the<br>in in bed or the resident<br>bed. |                          |   |   |                          |
|                          | by:<br>Based on observati<br>review, the facility fa<br>assess pain and im<br>relieve moderate to<br>surgical procedure<br>resident (R83) revie<br>monitor skin conditi<br>reviewed with multij<br>deficient practice ca<br>Findings include;<br>R83's admission Mi<br>10/31/14, identified<br>included arthritis, of<br>procedure, malaise<br>walking. The MDS i<br>cognitive impairment<br>assistance for activ | ent is not met as evidenced<br>on, interview and document<br>ailed to comprehensively<br>plement interventions to<br>severe pain following a<br>to the lower back for 1 of 1<br>ewed for pain, and failed to<br>on for 1 of 1 resident (R51)<br>ole bruises to skin. This<br>aused actual harm to R83.                 |                          | Nursing staff have been educated of<br>following resident's plan of care, ind<br>following their group assignments we<br>they are to carry with them. Group<br>assignments reveal toileting, repose<br>and assistive devices residents required<br>LN have received education on folloplan of care for residents with bruise<br>DON/Designee will audit weekly x 3<br>months to assure NAR's are carrying<br>group sheets and are following<br>interventions listed on the care she<br>DON/Designee will monitor<br>documentations weekly to assure r<br>are following care plan on any reside<br>with care plan related to bruising.<br>Findings from audits will be reviewed<br>QAA x 3 months to assure trends of<br>negative findings of audits are correct | cluding<br>which<br>itioning<br>juire.<br>owing<br>sing.<br>3<br>ng their<br>eet.<br>hurse's<br>dent<br>ed at<br>or |                          |

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|                          | ota Department of He   |  |                     |  |                                |                          |
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|                          | NT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION  |                                | E SURVEY<br>PLETED       |
|                          |  | 00679  | 79 B. WING          |  | 01/                            | 16/2015                  |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY,        | STATE, ZIP CODE  |                                |                          |
| FAIR OA                  | KS LODGE   |  | DY LANE DF          |  |                                |                          |
|                          |  | WADENA   | , MN 56482          |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | Continued From pa  | ige 16   | 2 830               |  |                                |                          |
|                          | moderate pain, recomedications, as new<br>and non-pharmacomanagement.<br>The Care Area Assi-<br>indicated the goal wislow/minimize decli<br>of functioning. The<br>decline and physical<br>contributing/limiting<br>The Pain Data Colled<br>dated 10/31/14, ide<br>pain, but has noted<br>cares and activity, uigoal, and irritability<br>The MDS dated 11/<br>cognitive impairment<br>identified R83 had with<br>and constant, seven<br>that R83 had felt time<br>every day. The MDS<br>scheduled pain ment<br>the use of any PRN<br>identified R83 had with<br>interventions for pain<br>R83's pain at a 10 of<br>worst pain).<br>R83 was admitted the<br>According to the rector<br>to the facility on 12/<br>discitis of the lumba<br>R83 was readmitted<br>medications ordere<br>-Fentanyl (narcotic<br>severe pain) patch<br>72 hours<br>-Tylenol Extra Stremmouth as needed for | eived scheduled pain<br>eded pain (PRN) medications<br>logical interventions for pain<br>essment (CAA) dated 11/4/14,<br>vas for improvement,<br>ine and maintain current level<br>CAA identified a mood<br>al limitations as<br>affect.<br>ection and Assessment form<br>entified R83 did not verbalize<br>grimacing and frowning with<br>unable to determine R83's pain<br>and change in mood noted.<br>/21/14, identified moderate<br>nt with no change. MDS<br>worsening mild depression<br>re pain. The MDS identified<br>ed or had little energy almost<br>S identified R83 was on<br>dications, and did not identify<br>I pain medications. MDS<br>non-pharmacological<br>in management and rated<br>on a scale of 1-10 (10 being<br>to the hospital on 12/17/14.<br>cord R83 had been readmitted<br>(23/14, with a diagnosis of<br>ar region.<br>d with the following pain<br>d:<br>pain medication to treat<br>25 mcg transdermally every<br>mgth tablet, 500 mg, 1 tablet by<br>pur times daily (QID) for pain<br>ngth tablet, 500 mg, 2 tablets |                     | Corrected Action is to be of 2.25/15   | completed by                   |                          |
|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                        |  |
|--------------------------|---|--|---------------------|--|-------------------------------|------------------------|--|
|                          |   | 00679  | B. WING             |  | 01/                           | 01/16/2015             |  |
|                          | PROVIDER OR SUPPLIER  |  | DDRESS, CITY, S     |  |                               | 10/2013                |  |
|                          |   |  |                     |  |                               |                        |  |
|                          | KS LODGE  | WADENA   | , MN 56482          |  |                               |                        |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE                | (X5)<br>COMPLE<br>DATE |  |
| 2 830                    | Continued From pa   | age 17   | 2 830               |  |                               |                        |  |
|                          | narcotic to treat mo<br>since 10/24/14<br>-Lidoderm Patch of<br>R83's readmission<br>identified moderate<br>moderate depressi<br>The MDS identified<br>The Admit/Readmin<br>12/23/14, identified<br>region and R83 ind<br>indicated on asses<br>pain, activity makes<br>it better, the pain at<br>he wanted to die. T<br>R83 would not com<br>ADLs.<br>Physical therapy (F<br>R83 from 12/24/14<br>discharge summar<br>R83 was significan<br>barely able to comp<br>(AROM) in bed with<br>Occupational thera<br>for 12/24/14 to 1/22<br>of after 4 weeks of<br>maximum level of f<br>restrictive environm<br>identified that R83<br>comb his hair even<br>perform ADLs witho<br>throughout treatme<br>therapy notes that<br>and pain. R83 was<br>1/2/15, and include<br>wished he could ge<br>that's done for him<br>him.<br>The care plan date | phen and hydrocodone -<br>oderate to severe pain) on hold<br>liscontinued 12/23/14<br>, 5 day MDS dated 12/30/14,<br>e cognitive impairment,<br>on and constant, severe pain.<br>I R83's pain to be 10/10.<br>t Pain Assessment dated<br>I R83 had pain to the lumbar<br>licated pain was severe. R83<br>sment that he had stabbing<br>s it worse, laying down makes<br>wakens him and R83 voiced<br>'he assessment identified that<br>tribute to performance of his<br>PT) services were provided for<br>to 1/2/15, for back pain. PT's<br>y from 1/2/15, identified that<br>tly limited by pain, and was<br>oblete active range of motion<br>nout excruciating pain.<br>py (OT) services were ordered<br>4/15. The OT identified a goal<br>OT, R83 would regain<br>function to discharge to least<br>nent. The OT evaluation<br>was unable to wash his face or<br>with set-up and unable to<br>out extensive assistance<br>ent due to pain. OT identified in<br>R83 was limited by weakness<br>discontinued from OT on<br>d R83's statement of he<br>et out of here because anything<br>is wrong, and doesn't work for<br>d 12/8/14, included diagnoses<br>nspecified general location |                     |  |                               |                        |  |

|                          | NT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING: _ | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------------|--|-----------------------------------|-------------------------|
|                          |  | 00679   | B. WING                         |  | 01/                               | 16/2015                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, ST                 | TATE, ZIP CODE   |                                   |                         |
|                          | KS LODGE   | 201 SHAI  |                                 | /E   |                                   |                         |
|                          |  | WADENA  | , MN 56482                      |  |                                   | -                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa  | ge 18   | 2 830                           |  |                                   |                         |
|                          | fatigue and difficulty<br>included back brace<br>ADLs and update M<br>care plan goal ident<br>relieved in 1 hour of<br>interventions includ<br>signs of pain and di<br>restlessness, wincin<br>assessment per pro-<br>medication as order<br>effectiveness. Report<br>to aid in comfort as<br>anticipate all pain n<br>language and facial<br>identified to observer<br>medications and up<br>and to assess for ca<br>and time spent in be<br>develop a plan of ca<br>non-pharmacologic<br>On 01/13/2015, at 8<br>"ow" and groaning i<br>R83 told licensed p<br>wanted to go back t<br>assisting in the dining<br>grimace, tilting his h<br>teeth in pain in the dining<br>grimace, tilting his h<br>teeth in pain in the dining<br>out "ow" and groan<br>LPN-B asked R83 i<br>different pain.<br>On 01/13/2015, at 9<br>that R83 had not ha<br>LPN-B to park him<br>cart because she w<br>residents' pills. R83 | dure other, other malaise and<br>y walking. ADL interventions<br>e, provide assistance with<br>1D/family with changes. Pain<br>tified R83's pain will be<br>f intervention. Pain<br>ed: observe for and report<br>scomfort, verbal complaints,<br>ng, moaning, guarding. Pain<br>otocol and prn. Pain<br>red by MD, monitor use and<br>ositioning and body alignment<br>resident allows. Staff to<br>eeds, i.e changes in body<br>I grimacing. Care plan also<br>e use and effectiveness of<br>odate family with any changes<br>omfort including loneliness<br>ed. The facility failed to<br>are for R83 to include |                                 |  |                                   |                         |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|---|-----------------------------|--|-----------------------------------|-------------------------|
|                          |  | 00679   | B. WING                     |  | 01/                               | 16/2015                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, ST            | TATE, ZIP CODE   |                                   |                         |
| FAIR OA                  | KS LODGE   |   | DY LANE DRIV<br>A, MN 56482 | /E   |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa  | age 19  | 2 830                       |  |                                   |                         |
|                          |  | n. LPN-A did not acknowledge<br>d dishing up other residents'   |                             |  |                                   |                         |
|                          | out "ow" in pain in t  | 9:08 a.m. R83 continued to cal<br>the hallway next to the LPN,<br>give R83 medication or<br>/ way.  | I                           |  |                                   |                         |
|                          | medication crushed<br>LPN-A told R83 he<br>yet. LPN-A told hou<br>available to transfe   | 9:13 a.m. LPN-A provided<br>d in applesauce with a spoon.<br>was not going to go to bed<br>usekeeping there was no one<br>r R83 to bed yet and he can't<br>3 was seated in the day area<br>s near the TV.   |                             |  |                                   |                         |
|                          | legs, and chest rea<br>much. R83 describ<br>that comes and goo<br>R83 described his p<br>running over his he<br>stated his wrist hur<br>lays too long he ha<br>near his thigh and t<br>stated pain goes fro<br>10 it lasts for 8-10 s<br>noise when he is ho<br>they will get him so<br>"Sometimes I get s | a.m. R83 stated his back,<br>illy hurt, but hips not quite as<br>ed his pain as shooting pain<br>es in his back and his legs.<br>pain as it feels like someone is<br>ad on the railroad tracks. R83<br>ts too. R83 stated that if he<br>s muscle pain in his right leg,<br>that it hurt at that time. R83<br>om 1-10, and when it gets to<br>seconds. R83 stated he makes<br>urting, he hollers and staff say<br>me medicine. R83 stated,<br>omething, and sometimes I<br>macing, short of breath and<br>g the interview. |                             |  |                                   |                         |
|                          | R83's call light afte<br>lay down because I<br>stated the staff see<br>but it doesn't really   | 9:53 a.m. the surveyor pushed<br>r he requested he wanted to<br>his bottom was hurting. R83<br>em to think the cushion helps,<br>help keep his bottom from<br>I he use to do therapy  |                             |  |                                   |                         |

| STATEMEN      | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  | ECONSTRUCTION  |                 | E SURVEY<br>PLETED |
|---------------|---|--|--|--|-----------------|--------------------|
|               |   |  | A. BUILDING:           679         B. WING |  |                 |                    |
|               |   | 00679  |  |  | 01/             | 01/16/2015         |
| NAME OF I     | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S                             | TATE, ZIP CODE   |                 |                    |
| FAIR OA       | KS LODGE  |  | Y LANE DRI<br>MN 56482                     | VE   |                 |                    |
| (X4) ID       |   | TEMENT OF DEFICIENCIES   | ID   | PROVIDER'S PLAN OF   |                 | (X5)               |
| PREFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                              | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE    |
| 2 830         | Continued From pa   | ige 20   | 2 830                                      |  |                 |                    |
|               | because he couldn'<br>him to. R83 stated  | e and then they passed him up<br>'t do the things they wanted<br>he had PT and pretty soon<br>nt to try anymore because it<br>' gave up.   |  |  |                 |                    |
|               | On 01/13/2015, at 10:07 a.m. registered nurse (RN)-A and NA-C were observed transferring R83 from wheelchair to bed. R83 was unable to lift his feet and cried out, "I can't." RN-A and NA-C told R83 to lean forward and put a sling under both arms. RN-A and NA-C told R83 to lean forward again, hold on and stand up. R83 cried out "ow" loudly, and NA-C told him to use his legs. R83 continued to cry out, hold his breath, moaning and saying "ow" for the duration of the transfer and was still grimacing, moaning and holding his breath after he was transferred into bed. |  |  |  |                 |                    |
|               |   | p.m. R83 was observed<br>ap. R83 rated his pain 6-8 in<br>ovement.   |  |  |                 |                    |
|               | performing R83's m<br>hurt all over. NA-B<br>complaints of pain.<br>hurt so bad and his<br>his leg to put socks<br>wincing in pain. R83<br>grimacing and sighi<br>attempted to put R8<br>"Oh my neck, back<br>were put on. R83 st<br>NA-B did not respo<br>of 10 and left the ro<br>transfer R83 into his   | 7:50 a.m. NA-B was observed<br>horning cares. R83 stated he<br>did not respond to R83's<br>R83 went on to say his feet<br>sheels burned. NA-B touched<br>on, R83 was grimacing and<br>3 calling out "ow" and<br>ing in pain while NA-B<br>B3's shoes on. R83 calling out,<br>and legs" when gripper socks<br>tated his pain was at a 10.<br>nd to R83 about his pain rating<br>bom. RN-A assisted NA-B to<br>s wheelchair. R83 was |  |  |                 |                    |
|               | was yelling, "I'm no  | ng out, "Oh my back." R83<br>t ready, ow, I cant take this."<br>me on." R83 was calling out  |  |  |                 |                    |

|                          | a Department of He  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--------------------------|---|---|-----------------------------|--|----------------------------------|-------------------------|
|                          |   | 00679   | B. WING                     |  | 01/16/2015                       |                         |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, ST             | TATE, ZIP CODE   |                                  |                         |
| FAIR OAP                 | (S LODGE  |   | DY LANE DRI\<br>., MN 56482 | /E   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
|                          | get you some Tylen<br>R83's back feels be<br>God no it doesn't fe<br>acknowledge R83's<br>going to brush his t<br>would be back to ta<br>continued to cry our<br>pushed R83 up to b<br>water on. R83 conti<br>as he was grimacin<br>brushing.<br>On 01/14/2015, at 8<br>and LPN-A did not a<br>continued to dish up<br>continued to dish up<br>continued to say "o"<br>LPN-A told R83, "H<br>ready here."<br>On 01/14/2015, at 8<br>pain, "ow", gasping<br>applesauce.<br>On 01/14/2015, at 8<br>and saying "ow" in f<br>R83 if he wanted to<br>stated he did want f<br>staff person that R8<br>was brought to sit in<br>On 01/14/2015, at 9<br>dayroom and told F<br>second.<br>On 01/14/2015, at 9<br>were observed assi<br>wheelchair. R83 sta | ge 21<br>amn bad." RN-A stated, "We'll<br>ol or something." NA asked if<br>etter and R83 stated, "No, Oh<br>eel better." NA-A did not<br>a pain and told R83 he was<br>eeth and RN-A stated she<br>ke R83 to breakfast. R83<br>t, "Oh my back" as NA-A<br>bathroom sink and turned the<br>nued to call out "ow, ow, ow",<br>g and panting with teeth<br>3:18 a.m. R83 cried out "ow",<br>acknowledge him. LPN-A<br>b other residents' pills. R83<br>w" and grimace and pant.<br>old on, I am just getting it<br>3:21 a.m. R83 yelling out in<br>. LPN-A gave R83 pills in<br>3:59 a.m. R83 was grimacing<br>the dining room. LPN-A asked<br>go back to his room. R83<br>to go to his room. LPN-A told a<br>33 was having pain and R83<br>in the back of dayroom.<br>0:22 a.m. NA-C came to<br>as he could lay down in a<br>0:24 a.m. NA-C and NA-A<br>isting R83 into bed from<br>ated his shoulders and back<br>ated R83's back had been |                             | DEFICIENC  | Υ)                               |                         |

|               | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             |  |                | E SURVEY<br>PLETED |
|---------------|---|--|-----------------------------|--|----------------|--------------------|
|               |   | 00679  | B. WING                     |  | 01/            | 16/2015            |
| NAME OF I     | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, ST            | TATE, ZIP CODE   |                |                    |
| FAIR OA       | KS LODGE  |  | DY LANE DRIV<br>A, MN 56482 | /E   |                |                    |
| (X4) ID       | SUMMABY STA   |  |                             | PROVIDER'S PLAN OF   | COBBECTION     | (X5)               |
| PREFIX<br>TAG | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG               | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE | COMPLET<br>DATE    |
| 2 830         | Continued From pa   | age 22   | 2 830                       |  |                |                    |
|               | grimacing, trying to<br>calling out, "Oh my<br>"Why does everythic<br>continued to grimace<br>told NA-C that R83<br>him down. NA-A and<br>had a lot of pain and<br>in bed. The NAs co<br>whenever he is in he<br>they move or transf<br>R83 has been in part<br>level depends on the<br>reviewed their care<br>was nothing on the<br>plan about pain. No<br>take R83's pain aw<br>pain medications we<br>that the only non-ph | Iding his breath in the lift,<br>catch his breath. R83 was<br>neck." R83 asked the NAs,<br>ing have to hurt so bad." R83<br>ce and cry out in bed. NA-A<br>always does this when you lay<br>of NA-C confirmed that R83<br>id he is the most comfortable<br>onfirmed that R83 had pain<br>his wheelchair or whenever<br>fer him. Both NAs confirmed<br>ain since admission and his<br>he time of day. Both NAs<br>sheet and stated that there<br>ir care sheets from the care<br>A-A stated the surgery did not<br>ay like it should have, and the<br>vere not working. NA-A stated<br>harmacological intervention for<br>ay him down in bed. |                             |  |                |                    |
|               | had pain since his of<br>didn't work. NA-B s<br>looks like he is dyin<br>pain limits his daily<br>bed the most. NA-E<br>best they can. NA-E<br>he feels horrible an<br>die. NA-B stated the<br>intervention for R83<br>him once in a while<br>NA-B stated R83 so<br>medicine dependin<br>On 01/14/2015, at 8  | a.m. NA-B stated R83 has<br>operation and the surgery<br>tated that sometimes R83<br>og in pain. NA-B stated R83's<br>activities and R83 likes his<br>feels they control his pain the<br>stated R83 always tells him<br>of he wants to fall asleep and<br>e non-pharmacological<br>B's pain was to try to position<br>and he wears a back brace.<br>ometimes asks him for<br>g on his pain and mood.<br>8:28 a.m. RN-A stated R83<br>back offer back argery and  |                             |  |                |                    |
|               | possible abscess. I more because of hi  | s back after back surgery and<br>RN-A stated R83 is in bed<br>is back. RN-A stated R83<br>h transfers. She added an  |                             |  |                |                    |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING: _ | CONSTRUCTION   |                | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------------|--|----------------|-------------------------|
|                          |  | 00679   | B. WING                         |  | 01/16/2015     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST                | TATE, ZIP CODE   |                |                         |
| FAIR OA                  | KS LODGE   |   | DY LANE DRI\<br>A, MN 56482     | VE   |                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | acceptable pain lew<br>perform transfers a<br>activities. RN-A star<br>pain and doesn't al-<br>but felt R83's pan w<br>medications. RN-A<br>since admission an<br>or nursing rehab. R<br>R83's pain level, bu<br>depending on what<br>confirmed R83's ca<br>non-pharmacologic<br>rest.<br>On 01/14/2015, at 8<br>has chronic pain. N<br>didn't work and thar<br>stated R83 has pair<br>yanks his body with<br>R83's pain severely<br>stated she felt that<br>but they try to do w<br>stated what helps F<br>NA-J stated she kn<br>working by talking t<br>reposition him with<br>stated that every tir<br>will tell you he is in<br>R83's daily pain wa<br>yelling out in pain d<br>repositioned every | rel for R83 is when he can<br>and can perform his daily<br>ted R83 complains daily of<br>ways ask for pain medication,<br>vas controlled with prn<br>stated R83 had been in pain<br>id no longer receives PT, OT<br>N-A stated she is not sure of<br>at felt it was mild to moderate<br>he was doing. RN-A<br>are plan and only contained the<br>cal intervention of letting him<br>8:40 a.m. NA-J stated that R83<br>IA-J stated R83's surgery<br>t nothing seems to work. NA-J<br>n 24/7 and if R83 moves he<br>n sharp pain. NA-J stated that<br>/ limits his daily living. NA-J<br>R83's pain was not controlled,<br>hat the doctor says. NA-J<br>R83's pain is if he lays in bed.<br>ows when the medicine is<br>to him and they can toilet and<br>put R83 screaming. NA-J<br>ne you move or turn R83 he<br>pain. NA-J stated that she felt<br>is between 7-8 and that he is<br>aily. NA-J stated R83 is to be<br>2 hours and use his back<br>macological interventions. | 8                               |  |                |                         |
|                          | sees R83 in pain m<br>pain.  | 8:50 a.m. LPN-B stated she<br>lost days, and that he jumps in<br>a.m. LPN-C stated R83 does   |                                 |  |                |                         |
|                          | have pain. LPN-C s   | stated she can tell if R83's pair<br>ding on his mood, and if he is   |                                 |  |                |                         |

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION  | Alth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING: _ | CONSTRUCTION   |               | E SURVEY<br>PLETED       |
|--------------------------|--|--|---------------------------------|--|---------------|--------------------------|
|                          |  | 00679  | B. WING                         |  | 01/16/2015    |                          |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, ST                | TATE, ZIP CODE   |               |                          |
| FAIR OA                  | KS LODGE   |  | DY LANE DRI\<br>A, MN 56482     | /E   |               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLETI<br>DATE |
| 2 830                    | Continued From pa  | ige 24   | 2 830                           |  |               |                          |
|                          | stated an acceptab<br>be 0, comfortable, p<br>pain medication wa<br>and did not want to<br>stated if R83 is born<br>stated R83's averag<br>he moves 5-8, and<br>LPN-C stated, "I do<br>for him, if he has pa<br>more of a fall risk."<br>On 01/14/2015, at<br>complains more wh<br>down. LPN-A stated<br>down. LPN-A stated<br>down. LPN-A stated<br>chronic. She stated<br>out during transfers<br>sensitive area. LPN<br>acceptable level of<br>should have pain.<br>anything for R83's p<br>narcotics. LPN-A st<br>not debilitating. LPI<br>was calling out mor<br>LPN-A stated the m<br>the more his pain is<br>that the facility has<br>for different pain m<br>emailed the directo<br>her to quit asking fo<br>what they were doin<br>a history of alcoholi<br>from hospital his liv<br>requiring low dose<br>On 01/14/2015, at 2<br>R83 did not trigger | he won't complain. LPN-C<br>le level of pain for him would<br>pain free. LPN-C stated his<br>is effective if he was happy<br>lay down as much. LPN-C<br>ed, then he has pain. LPN-C<br>ge pain if he lays still is 2-3, if<br>it depends on what's wrong.<br>It know what more we can do<br>ain medications then he is<br>12:55 p.m. LPN-A stated R83<br>hen he is up and wants to lay<br>d R83 always wants to lay<br>d R83 always wants to lay<br>d she felt R83's pain was<br>l she would expect R83 to call<br>s because his back is a<br>I-A stated she felt an<br>pain for R83 is none, no one<br>LPN-A stated it is hard to do<br>pain, and R83 is sensitive to<br>ated she felt that R83's pain is<br>N-A stated that she felt R83<br>re, and he likes attention.<br>hore you pay attention to him,<br>s exaggerated. LPN-A stated<br>asked the doctor many times<br>edications, and the doctor<br>r of nursing (DON) and told<br>or pain medications, so that is<br>ng. LPN-A stated that R83 had<br>sm and when he came back<br>er function was impaired<br>pain medication. |                                 |  |               |                          |

| STATEMEN      | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION  |                 | E SURVEY<br>PLETED |
|---------------|---|---|-----------------------------|---|-----------------|--------------------|
|               |   |   | A. BUILDING: _              | · · · · · · · · · · · · · · · · · · ·                   |                 |                    |
|               |   | 00679   | B. WING                     |   | 01/16/2015      |                    |
| NAME OF I     | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, ST             | TATE, ZIP CODE  |                 |                    |
| FAIR OA       | KS LODGE  |   | DY LANE DRI\<br>., MN 56482 | /E  |                 |                    |
| (X4) ID       | SUMMARY STA   | TEMENT OF DEFICIENCIES  | ID                          | PROVIDER'S PLAN OF                                      | CORRECTION      | (X5)               |
| PRÉFIX<br>TAG |   | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG               | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE    |
| 2 830         | Continued From pa   | ge 25   | 2 830                       |   |                 |                    |
|               | laying down alleviat<br>it worse. RN-A conf<br>dated 12/23/14, that<br>to die. The assess<br>prevents R83 from<br>performance of his<br>participation and R8<br>because of his pain<br>aware that R83 was<br>(MD name) and the<br>were aware that R8<br>RN-A stated she wo<br>in pain. RN-A stated<br>R83's pain was mo<br>in December 2014,<br>assessment. RN-A<br>really does not wan<br>R83's pain medicat<br>antibiotic on Januar<br>repeat MRI. RN-A s<br>of what we can do,<br>medications and do<br>think of anything els<br>pain." RN-A confirm<br>regimen.<br>On 01/14/2015, at 3<br>Interviewed. RN-C | k pain. LPN-A stated that<br>tees his pain and activity makes<br>irmed the pain assessment<br>it R83 will voice he just wants<br>nent also indicated R83's pain<br>contributing to the<br>ADLs, limits his activity<br>83's mobility is decreased<br>a. RN-A stated that she was<br>a calling out in pain and that<br>e nurse practitioner (GNP)<br>33 was calling out in pain.<br>buld not expect R83 to call out<br>d she was not aware that<br>derate in November 2014, and<br>R83's pain was 10/10 on<br>a stated she knew that doctor<br>t to make any changes to<br>ions until R83 completes his<br>ry 30th, 2015, and has a<br>stated, "I honestly am not sure<br>we have tried different<br>oses, and heat packs. I cant<br>se we can do to treat R83's<br>ned R83's pain medication<br>8:11 p.m. RN-C and DON were<br>stated R83 had fallen and had<br>res to his vertebrae. RN-C<br>syphoplasty procedure for |                             |   |                 |                    |
|               | RN-A stated they w<br>anything else for pa<br>stated that R83 car<br>medication for mod   | NP-A to address R83's pain.<br>ere told 83 was not getting<br>ain and to stop asking. RN-C<br>ne back on Vicodin (narcotic<br>erate to severe pain).The   |                             |   |                 |                    |
|               | R83 now gets Tyler  | hold due to behaviors and<br>nol and the Fentanyl patch<br>n through patch on skin).  |                             |   |                 |                    |

| STATEMEN          | ota Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             | CONSTRUCTION                               |               | E SURVEY<br>PLETED      |  |
|-------------------|--|--|-----------------------------|--|---------------|-------------------------|--|
|                   |  |  | B. WING                     |  |               |                         |  |
|                   |  | 00679  |                             |  | 01/           | 16/2015                 |  |
| NAME OF           | PROVIDER OR SUPPLIER   |  | DRESS, CITY, ST             |  |               |                         |  |
| FAIR OA           | KS LODGE   |  | )Y LANE DRI\<br>, MN  56482 |  |               |                         |  |
| (X4) ID<br>PREFIX | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL   | ID<br>PREFIX                | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT | ION SHOULD BE | (X5)<br>COMPLET<br>DATE |  |
| TAG               | REGULATORY OR L  | SC IDENTIFYING INFORMATION)  | TAG                         | CROSS-REFERENCED TO T<br>DEFICIENC         |               | DATE                    |  |
| 2 830             | Continued From pa  | ige 26   | 2 830                       |  |               |                         |  |
|                   | about R83's kidney<br>meanwhile they kee<br>RN-C stated R83's<br>receive Vicodin as<br>confused and falling<br>to him on and off the<br>no way to live. RN-G<br>R83 does not have<br>chemical depender<br>RN-C R83's history<br>and liver function. If<br>nothing in R83's me<br>alcoholism history a<br>prescribing other na<br>On 01/15/2015, at 8<br>interviewed and sta<br>medical director inv<br>management.<br>On 01/15/2015, at 8<br>occupational therap<br>interviewed. COTA<br>discharged from the<br>COTA stated that F<br>problem. The COT/<br>and R83's family th<br>not helping and R8<br>The COTA stated F<br>limited his ability to<br>R83 does not get n<br>walking schedule b<br>stated R83 was una<br>services because of<br>pain was severe, cl<br>COTA stated R83's<br>and it is a shooting | by assistant (COTA) was<br>stated that R83 was<br>erapy after about a week. The<br>R83's back pain was the main<br>A stated that between therapy<br>ey decided that therapy was<br>3 was not making progress.<br>R83's pain was continuous and<br>participate. The COTA stated<br>ursing rehab and was not on a<br>ecause of pain. The COTA<br>able to receive range of motion<br>of pain. The COTA stated R83's<br>hronic and every day. The<br>pain was when he is moving<br>pain. R83 winces when he just |                             |  |               |                         |  |
|                   | sits in his chair. CC  | TA stated R83 had stated to  |                             |  |               |                         |  |
|                   | her that he wishes   | he would die because of the  |                             |  |               |                         |  |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION   |                                   | E SURVEY<br>PLETED     |
|--------------------------|--|---|-----------------------------|--|-----------------------------------|------------------------|
|                          |  | 00679   | B. WING                     | B. WING  |                                   | 16/2015                |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, ST            | TATE, ZIP CODE   |                                   |                        |
| AIR OA                   | KS LODGE   |   | DY LANE DRIN<br>A, MN 56482 | /E   |                                   |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 2 830                    | pain, and wished it<br>stated R83's feeling<br>stated that the fami<br>medication because<br>COTA stated when<br>and disoriented and<br>medications he was<br>she would see R83<br>medication in the m<br>in bed was really ha<br>when R83 was rolle<br>and going from sup<br>say "that kills me do<br>She stated she let t<br>much pain and ask<br>medication because<br>the doctor and fami<br>COTA stated R83 | ge 27<br>would just go away. COTA<br>gs were understandable. COTA<br>ly and doctors limit R83's pain<br>e it made R83 disoriented.<br>R83 was admitted he was lost<br>d when he was taken off pain<br>s more clear. The COTA stated<br>before he got his pain<br>norning. COTA stated sitting up<br>ard for R83. COTA stated<br>ed on his side he would wince<br>ine to sitting and R83 would<br>bing when your doing that."<br>he nurse know he had that<br>ed if R83 can have pain<br>e he was only on Tylenol per<br>ly, and they decided not to.<br>did not improve at all during<br>as discharged from therapy | I                           |  |                                   |                        |
|                          | interviewed. GNP-A<br>pain. GNP-A stated<br>things for pain, and<br>him falling they tool<br>pain patch. GNP-A<br>best thing in the wo<br>pulling at it. GNP-A<br>just like to have a d<br>GNP-A stated R83<br>main floor was the<br>when R83 was ups<br>GNP-A stated she t<br>pain and he wanted<br>surgeon and do and<br>an abscess, and the<br>something. GNP-A   | 2:20 a.m. the GNP-A was<br>a stated R83 was in constant<br>R83 has been on so many<br>stated because of their fear of<br>a away narcotics and left the<br>stated the brace was not the<br>rld and R83 constantly keeps<br>stated R83 tells her he would<br>rink when she sees him.<br>was still having pain and the<br>best floor for him because<br>tairs he dwelled on his pain.<br>alked to his MD about R83's<br>to wait 6 weeks per the<br>other MRI as R83 could have<br>en surgically they would do<br>a stated, "We have tried<br>point we took [R83] off all his<br>cept for Tylenol with no               | F                           |  |                                   |                        |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING: _ | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|--|---------------------------------|--|-----------------------------------|-------------------------|
|                          |  | 00679  | B. WING                         |  | 01/16/2015                        |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, ST                 | ATE, ZIP CODE  |                                   |                         |
|                          |  | 201 SHA  |                                 | /E   |                                   |                         |
| -AIR OA                  | KS LODGE   | WADENA   | , MN 56482                      |  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa  | ge 28  | 2 830                           |  |                                   |                         |
|                          | matter what we give<br>cognitive level decli<br>times he will not ge<br>"Nothing we have d<br>of pain. Not sure is<br>kidneys bad, livers<br>nothing has change<br>either groggy or his  | pain stayed the same no<br>e him." GNP-A stated if R83's<br>ines and he falls one too many<br>t better. GNP-A stated,<br>lone has changed [R83's] level<br>he's a surgical candidate,<br>worse. Nothing we have done,<br>ed the level of pain. R83 is<br>back hurts." GNP-A stated it<br>ul with R83 and his level of<br>me.   |                                 |  |                                   |                         |
|                          | (FM)-A was intervie<br>concerned regardin<br>doctor about R83's<br>MD says R83 can o<br>that. FM-A stated, "<br>this much pain. I was<br>surgery he fell down<br>R83 has fallen 2-3<br>the hospital and dio<br>stated he was cono<br>falls only a week af<br>complaining of pain<br>FM-A stated he was | 3:25 p.m. family member<br>wed. FM-A stated he was<br>ing the follow up from the<br>pain. FM-A stated that if the<br>do better then R83 would want<br>I don't know why he is still in<br>as told that after his back<br>in a couple times." FM-A stated<br>times since he got back from<br>I not see the doctor. FM-A<br>erened after R83 was having<br>ter back surgery and was<br>in, and has not seen the doctor.<br>is concerned that there was no<br>something happened to R83's<br>is after surgery. |                                 |  |                                   |                         |
|                          | satisfied with his pa<br>keep saying they ar<br>they don't do anythi<br>worried about rocki<br>his pain. R83 stated<br>when he was laying<br>shooting pain when<br>seems like nothing<br>want to be dead, no   | 2 p.m. R83 stated he not<br>ain control. R83 stated, "They<br>re going to do something, and<br>ing." R83 stated he was<br>ng the boat if he talks about<br>d his pain was about 5/10<br>g down in bed, and 10/10 with<br>he moves. R83 stated it<br>can be done for him. " I don't<br>bbody wants to be dead. There<br>times that I have I talked  |                                 |  |                                   |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION  |                                 | E SURVEY<br>PLETED      |
|--------------------------|---|---|-----------------------------|---|---------------------------------|-------------------------|
|                          |   | 00679   | B. WING                     |   | 01/                             | 16/2015                 |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST            | TATE, ZIP CODE  |                                 |                         |
| AIR OA                   | KS LODGE  |   | DY LANE DRI\<br>A, MN 56482 | /E  |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa   | age 29  | 2 830                       |   |                                 |                         |
|                          | about and felt I wanted to die." R83 stated he<br>wanted to die because he hurts. R83 also stated<br>that waiting to go to the bathroom makes him<br>sad, and says that's just the way it is.   |   |                             |   |                                 |                         |
|                          | and DON were inte<br>they can assess, bu<br>when a MD is adan<br>something else for<br>did not document th  | 4:16 p.m. the administrator<br>erviewed. Administrator stated<br>ut asked what they can do<br>nant about not giving<br>pain. DON stated that LSW<br>he statements about wanting<br>that R83 meant he was ready<br>vanting to die.   |                             |   |                                 |                         |
|                          | (MD)-A was intervie<br>stated that R83's pro-<br>kept her in the loop<br>contacted her to ster<br>management. MD-<br>when R83 is at rest<br>gets up he is wincir<br>feels they had relat<br>R83 was not pain from<br>R83's statements of<br>better off dead. MD<br>yesterday about R8<br>still working on non<br>interventions for sign | 10:10 a.m. the medical director<br>ewed. The medical director<br>rimary MD and GNP-A have<br>o, but the facility has not<br>ep in to assist with R83's pain<br>-A stated she understands that<br>t that he is fine, but when he<br>ng in pain. MD-A stated she<br>ively controlled his pain, but<br>ree. She was not aware of<br>of wanting to die or that he is<br>0-A stated she talked to GNP-A<br>83's pain control, and they are<br>i-med therapies and other<br>de effects. MD-A stated she<br>what the non-pharmacological<br>being tried. |                             |   |                                 |                         |
|                          | current documente<br>-12/23/14, at 15:34<br>after hospitalization<br>continued to be in p   | ess notes following surgery to<br>d:<br>R83 returned to the facility<br>n, and the note identified R83<br>pain. No prn medication or<br>cal interventions documented  |                             |   |                                 |                         |

| STATEMEN      | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:     |                             | CONSTRUCTION   |                 | E SURVEY<br>PLETED |
|---------------|---|---|-----------------------------|--|-----------------|--------------------|
|               |   | 00679   | B. WING                     |  | 01/             | 16/2015            |
| NAME OF       | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST            | TATE, ZIP CODE   |                 |                    |
| FAIR OA       | KS LODGE  |   | DY LANE DRIV<br>A, MN 56482 | /E   |                 |                    |
| (X4) ID       |   | TEMENT OF DEFICIENCIES                                    | ID                          | PROVIDER'S PLAN OF                                       |                 | (X5)               |
| PREFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG               | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE    |
| 2 830         | Continued From pa   | age 30  | 2 830                       |  |                 |                    |
|               |   | a.m. identified R83 had                                   |                             |  |                 |                    |
|               |   | c pain with verbal and                                    |                             |  |                 |                    |
|               |   | rs of pain. Writer indicates that                         | t                           |  |                 |                    |
|               |   | I pain medications. No prn                                |                             |  |                 |                    |
|               | documented for R8   | pharmacological interventions                             |                             |  |                 |                    |
|               |   | identified R83 was showing                                |                             |  |                 |                    |
|               |   | is of pain with any activity and                          |                             |  |                 |                    |
|               |   | he is up out of bed in                                    |                             |  |                 |                    |
|               | wheelchair. No prn  |   |                             |  |                 |                    |
|               |   | al interventions documented                               |                             |  |                 |                    |
|               | for R83's pain.   |   |                             |  |                 |                    |
|               |   | a.m. R83 requested  |                             |  |                 |                    |
|               |   | pain rated 8/10. Tylenol given                            |                             |  |                 |                    |
|               |   | locumented as effective.                                  |                             |  |                 |                    |
|               |   | R83 has complaints of                                     |                             |  |                 |                    |
|               |   | nd stated it was a constant<br>Tylenol was given, none    |                             |  |                 |                    |
|               |   | 35 a.m. R83 got up for dinner                             |                             |  |                 |                    |
|               |   | d right after, still stating he had                       |                             |  |                 |                    |
|               |   | placed in bed. Writer                                     |                             |  |                 |                    |
|               |   | was resting with eyes closed                              |                             |  |                 |                    |
|               | since that then.  |   |                             |  |                 |                    |
|               |   | R83 continued to have                                     |                             |  |                 |                    |
|               |   | to his lower back with                                    |                             |  |                 |                    |
|               |   | given at HS with some relief.                             |                             |  |                 |                    |
|               |   | ication given or documentation                            | 1                           |  |                 |                    |
|               | pain.   | gical interventions for R83's                             |                             |  |                 |                    |
|               |   | a.m. R83 was complaining of                               |                             |  |                 |                    |
|               |   | al and non-verbal indicators of                           | :                           |  |                 |                    |
|               |   | hat R83 had scheduled pain                                |                             |  |                 |                    |
|               | medications. No pr  | · · · · · · · · · · · · · · · · · · ·                     |                             |  |                 |                    |
|               | non-pharmacologic   | al interventions documented                               |                             |  |                 |                    |
|               | for R83's pain.   |   |                             |  |                 |                    |
|               |   | R83 showing signs and                                     |                             |  |                 |                    |
|               |   | pain with facial grimacing and                            |                             |  |                 |                    |
|               |   | ated that scheduled HS Tyleno                             |                             |  |                 |                    |
|               |   | 83 was showing signs and                                  |                             |  |                 |                    |
|               | epartment of Health   | with any activity and                                     |                             |  |                 |                    |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |  |                                  | E SURVEY<br>PLETED      |
|--------------------------|--|--|---------------------|--|----------------------------------|-------------------------|
|                          |  | 00679  | B. WING             | B. WING  |                                  | 16/2015                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S     | TATE, ZIP CODE   | ·                                |                         |
|                          | KS LODGE   |  | DY LANE DRI         | VE   |                                  |                         |
|                          |  | WADENA   | A, MN 56482         |  |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa  | ge 31  | 2 830               |  |                                  |                         |
|                          | repositioning. No fu<br>non-pharmacologic<br>for R83's pain.<br>-12/27/14, at 1458<br>moaning with trans.<br>No prn medication<br>interventions docum<br>-12/28/14, at 14:28<br>symptoms of pain w<br>repositioning. No pr<br>non-pharmacologic<br>for R83's pain.<br>-12/30/14, at 15:27<br>lower back pain and<br>documented as effe<br>-12/31/14, at 15:27<br>lower back pain and<br>documented as effe<br>-12/31/14, at 1840<br>symptoms of back<br>guarding. Writer sa<br>helpful.<br>-1/1/15, at 12:59 R8<br>transfers and repor<br>medication or non-p<br>documented for R8<br>-1/1/15, at 20:22 R8<br>complaints of lower<br>that both prn and ti<br>only minimal relief f<br>back brace only pro<br>further prn medicat<br>interventions docum<br>-1/2/15, at 21:36 R8<br>signs and symptom<br>and reports pain an<br>medication docume<br>non-pharmacologic<br>-1/3/15, at 19:11 R8<br>prn Tylenol given. N<br>effectiveness or oth<br>interventions docum | rther prn medication or<br>al interventions documented<br>R83 was grimacing and<br>fers using the mechanical lift.<br>or non-pharmacological<br>nented for R83's pain.<br>R83 was showing signs and<br>vith transfers and<br>'n medication or<br>al interventions documented<br>R83 requested medication for<br>d rated pain 7/10. Tylenol was<br>ective.<br>R83 was showing signs and<br>pain with facial grimacing and<br>id that scheduled Tylenol was<br>33 yells out in pain with<br>ted back pain this shift. No prr<br>oharmacological interventions<br>3's pain.<br>33 continues to have<br>back pain. Writer indicates<br>he scheduled Tylenol provide<br>for R83. Writer also noted that<br>byided minimal relief. No<br>ion or non-pharmacological<br>nented for R83's pain.<br>33 has verbal and non-verbal<br>is of pain throughout the shift<br>id weakness to legs. No prn<br>ented or any documentation of<br>al interventions for R83's pain.<br>33 had back pain rated 9/10,<br>No documentation of Tylenol<br>her non-pharmacological | r                   |  |                                  |                         |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | CONSTRUCTION   |              | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------|--|--------------|-------------------------|
|                          |  | 00679   | B. WING             |  | 01/16/2015   |                         |
|                          | PROVIDER OR SUPPLIER   |   | DRESS, CITY, ST     | TATE, ZIP CODE   |              | 10/2013                 |
|                          |  |   | DY LANE DRIV        |  |              |                         |
|                          | KS LODGE   | WADENA  | , MN 56482          |  |              |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ITEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa  | ige 32  | 2 830               |  |              |                         |
|                          | medications. No prinon-pharmacologic<br>for R83's pain.<br>-1/6/15, at 7:31 a.m<br>signs and symptom<br>documentation of e<br>-1/6/15, at 8:53 a.m<br>nurse and writer up<br>nurse said that she<br>-1/9/15, at 8:57 a.m<br>buttocks leaning up<br>reach his urinal. R8<br>entire time. No prin<br>non-pharmacologic<br>for R83's pain or m<br>-1/10/15, at 11:42 F<br>was going out with<br>to back. Tylenol not<br>15:06.<br>-1/12/15, at 11:06 a<br>noted his fall of 1/9.<br>R83's medications<br>-1/13/15, at 9:18 p.1<br>hip pain and was gi<br>documented effecti<br>-1/14/15, at 8:33 a.1<br>for back pain, Tyler<br>documented effecti<br>he is in bed there is<br>The Pain Managem<br>identified that residu<br>regularly through of<br>daily care and/or of<br>symptoms of pain.<br>R51's care plan dat<br>observe skin with re<br>to nurse any chang | al interventions documented<br>a. R83 was grimacing and has<br>is of pain. Tylenol given, no<br>ffectiveness.<br>b. Call was received from MD's<br>idated her on R83's pain,<br>would update MD.<br>c. R83 was found sitting on his<br>b against his bed after trying to<br>a complained of back pain the<br>medication or<br>al interventions documented<br>edical attention pursued.<br>R83 was given prn Tylenol and<br>family to aid in his discomfort<br>t documented effective until<br>a.m. GNP visited R83 and<br>(15. GNP made no changes to<br>or orders.<br>m. R83 complained of bilateral<br>ven Tylenol. Tylenol<br>ve.<br>m. R83 requested medication<br>nol was administered and<br>ve. R83 stated that as long as |                     |  |              |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION  |                                   | E SURVEY<br>PLETED                  |  |
|--------------------------|---|---|-----------------------------|---|-----------------------------------|-------------------------------------|--|
|                          |   | 00679   | B. WING                     |   | 01/                               | 01/16/2015                          |  |
| IAME OF F                | PROVIDER OR SUPPLIER  |   | DDRESS, CITY, ST            | TATE, ZIP CODE  |                                   |                                     |  |
|                          | KS LODGE  |   | DY LANE DRI\<br>A, MN 56482 | /E  |                                   |                                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE <sup>-</sup><br>DATE |  |
| 2 830                    | Continued From pa   | age 33  | 2 830                       |   |                                   |                                     |  |
|                          | therapy. The care<br>complete weekly sl<br>documentation of r   |   |                             |   |                                   |                                     |  |
|                          | was cognitively inta<br>all activities of daily<br>R51 had diagnoses  | dated 12/29/14, indicated R51<br>act and required assistance for<br>living. The MDS indicated<br>which included degenerative<br>na, Parkinson's, diabetes<br>osteoarthritis.  |                             |   |                                   |                                     |  |
|                          | was seated in a wh<br>Observed one larg<br>approximately 3 x 3<br>forearm, also obse<br>bruises on resident<br>on resident's left fo<br>on the right forearm<br>ago when her arm<br>bed. R51 stated th<br>hand also happene<br>caused when staff<br>grab bar next to the<br>her shirt to assist h<br>by accident get her<br>reported that she d<br>bruises easily. R5<br>about the bruises, | n on 1/13/15, at 3:36 p.m. R51<br>neelchair next to the bed.<br>e dark purple bruise,<br>3 inches on the resident's right<br>reved 3 smaller dark purple<br>t's left hand and 1 small bruise<br>orearm. R51 stated the bruise<br>in happened a couple of days<br>bumped the grab bar on the<br>bruises on the left arm and<br>ed a couple days ago and were<br>assist her left arm up to the<br>e toilet. R51 stated staff grab<br>her left arm up to the toilet and<br>r skin in with her clothes. R51<br>loes take a daily aspirin and<br>1 stated she had not told staff<br>then stated she was sure staff<br>es because they help her get<br>passed everyday. |                             |   |                                   |                                     |  |
|                          | was evident to indi-<br>right and left forear   |   |                             |   |                                   |                                     |  |
|                          | was at risk for skin  | lated 9/29/14, indicated R51<br>breakdown related to limited<br>na, peripheral vascular disease   | ,                           |   |                                   |                                     |  |

| STATEMENT OF DEFICIENCIES (X1<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION   |                                   | E SURVEY<br>PLETED     |  |
|---|---|---|-----------------------------|--|-----------------------------------|------------------------|--|
|   |   | 00679   | -<br>B. WING                |  |                                   | 01/16/2015             |  |
| IAME OF I   | PROVIDER OR SUPPLIER  |   | DDRESS, CITY, S             | TATE, ZIP CODE   |                                   | 10/2010                |  |
| AIR OA  | KS LODGE  |   | DY LANE DRIV<br>A, MN 56482 | νE   |                                   |                        |  |
| (X4) ID<br>PREFIX<br>TAG                                | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |  |
| 2 830   | Continued From pa   | age 34  | 2 830                       |  |                                   |                        |  |
|   | directed licensed staff to complete weekly skin assessments.  |   |                             |  |                                   |                        |  |
|   | confirmed she assi<br>including dressing<br>R51 has real thin s<br>careful when movin<br>did not notice any r<br>had black and blue<br>hands. NA-B repo<br>those bruises on R<br>asked if NA-B had<br>nurses, she stated<br>always had those b<br>she came here to t<br>During interview or<br>reported R51 bruis | n 1/14/15, at 9:59 a.m. LPN-A<br>es very easily, but could not  |                             |  |                                   |                        |  |
|   | reviewing the medi<br>she was the nurse<br>stated staff would r<br>documenting bruis<br>resident's bath day<br>progress notes, an<br>progress note docu<br>indicated no conce<br>time. LPN-A stated<br>inspection would h<br>bath day) and conf<br>assessment docum   | es in the progress notes on the<br>rs. LPN-A reviewed R51's<br>d LPN-A reported the last<br>unented was on 1/2/15, and<br>erns to body surface at that<br>d R51's last weekly skin<br>ave been on 1/9/15 (R51's<br>irmed that the weekly skin<br>nentation was missing in the |                             |  |                                   |                        |  |
|   | no staff had reporte<br>handsor arms. LP  | kin condition. LPN-A confirmed<br>ed R51 having any bruising to<br>N-A stated she does not work<br>ttly, and works all three floors.  |                             |  |                                   |                        |  |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                          | CONSTRUCTION   |                                  | E SURVEY<br>PLETED       |
|--------------------------|--|--|--------------------------|--|----------------------------------|--------------------------|
|                          |  | 00679  | B. WING                  |  | 01/                              | 16/2015                  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, ST          | TATE, ZIP CODE   |                                  |                          |
| FAIR OA                  | KS LODGE   |  | DY LANE DRI\<br>MN 56482 | /E   |                                  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | Continued From pa  | ge 35  | 2 830                    |  |                                  |                          |
|                          | monitor the bruise i<br>resolved. The DON<br>to follow the care pl   | o the nurse can assess and<br>n the progress notes until<br>I confirmed staff are expected<br>an which included<br>s of weekly skin inspections.   |                          |  |                                  |                          |
|                          | Integrity/Wound Ma<br>September 13, 201<br>system in place for   | y's Pressure Ulcers/Skin<br>inagement policy dated<br>1, indicated the facility had a<br>the prevention, identification,<br>umentation of pressure and<br>ds.  |                          |  |                                  |                          |
|                          | The director of nurs<br>staff and perform a  | HOD OF CORRECTION:<br>sing or designee could train all<br>udits to ensure each resident<br>riate nursing care and  |                          |  |                                  |                          |
|                          | TIME PERIOD FOF<br>(21) days.  | R CORRECTION: Twenty One   |                          |  |                                  |                          |
| 2 840                    | MN Rule 4658.0520<br>Proper Nursing Car  | ) Subp. 2 B Adequate and<br>re; Clean skin   | 2 840                    |  |                                  | 2/16/15                  |
|                          |  | r determining adequate and<br>criteria for determining<br>er care include:   |                          |  |                                  |                          |
|                          | odors. A bathing pl<br>resident's plan of ca<br>condition requires t<br>must be given a co<br>other day and more | and freedom from offensive<br>an must be part of each<br>are. A resident whose<br>hat the resident remain in bed<br>mplete bath at least every<br>often as indicated. An<br>t must be checked at least |                          |  |                                  |                          |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            |   |   | SURVEY<br>PLETED        |
|--------------------------|--|---|----------------------------|---|---|-------------------------|
|                          |  | 00679   | B. WING                    |   | 01/16/2015  |                         |
|                          | PROVIDER OR SUPPLIER   |   | DDRESS, CITY, S            | TATE. ZIP CODE  |   | 10/2015                 |
|                          | KS LODGE   | 201 SHA   | DY LANE DRI<br>A, MN 56482 |   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | HOULD BE  | (X5)<br>COMPLET<br>DATE |
|                          | Continued From pa  | age 36  | 2 840                      |   |   |                         |
|                          | every two hours, and must receive perineal care following each episode of incontinence.  |   |                            |   |   |                         |
|                          | Notwithstanding Mi<br>4658.0520, an inco<br>checked according<br>written in the reside<br>attending physician<br>interval longer than<br>if competent, or a f<br>appointed conserva<br>agent of a resident<br>in writing to waive p<br>determining this int<br>documented in the<br>Clean linens or clop<br>promptly each time<br>Perineal care inclu-<br>the perineal area.<br>to keep the bed dry<br>comfort. Special a<br>skin to prevent irrita<br>types of protectors<br>completely covered<br>contact with the res | 1. Incontinent residents.<br>innesota Rules, part<br>ontinent resident must be<br>to a specific time interval<br>ent's care plan. The resident's<br>must authorize in writing any<br>two hours unless the resident<br>amily member or legally<br>ator, guardian, or health care<br>who is not competent, agrees<br>obysician involvement in<br>terval, and this waiver is<br>resident's care plan. ]<br>thing must be provided<br>the bed or clothing is soiled.<br>des the washing and drying of<br>Pads or diapers must be used<br>y and for the resident's<br>ttention must be given to the<br>ation. Rubber, plastic, or other<br>must be kept clean, be<br>d, and not come in direct<br>sident. Soiled linen and<br>emoved immediately from<br>revent odors. | ,                          |   |   |                         |
|                          | by:<br>Based observation<br>review, the facility f<br>residents (R102) in  | ent is not met as evidenced<br>, interview, and document<br>failed to ensure that 1 of 1<br>of the sample requiring<br>d timely assistance with   |                            | Nursing staff have been educ<br>following resident's plan of ca<br>following their group assignm<br>they are to carry with them. G<br>assignments reveal bathing, t<br>repositioning and assistive de | re, including<br>ents which<br>roup<br>coileting, |                         |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION  | (X3) DATE S<br>COMPL |                         |
|--------------------------|---|--|---------------------|--|----------------------|-------------------------|
|                          |   | 00679  | B. WING             |  | 01/16/2015           |                         |
| IAME OF I                | PROVIDER OR SUPPLIER  |  | DRESS, CITY,        | STATE, ZIP CODE  |                      |                         |
| AIR OA                   | KS LODGE  |  | , MN 56482          |  |                      |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | D BE                 | (X5)<br>COMPLET<br>DATE |
| 2 840                    |   | lge 37   | 2 840               | residents require.   |                      |                         |
|                          | Findings include:<br>R102's diagnoses included healing hip fracture,<br>right arm below the elbow amputee, and chronic<br>kidney disease. R102's quarterly Minimum Data<br>Set (MDS) dated 12/16/14, identified R102 was<br>cognitively intact. However, during an interview on<br>1/13/2015, at 9:55 a.m. R102 identified he was<br>not sure if he had eaten this morning and he had<br>already been observed to eat breakfast. R102<br>was also unaware that he lived in a nursing<br>home. The quarterly MDS also identified R102<br>required extensive assistance for toileting. R102's<br>current care plan dated to be revised 12/8/14,<br>identified he required toileting every two hours<br>and as needed. R102 was to be checked and<br>changed if already incontinent. |  |                     | LN are to update NAR's group<br>assignments PRN.<br>DON/Designee will audit weekly x<br>months to assure NAR's are carry<br>group sheets and are following<br>interventions listed on the care she | ing their            |                         |
|                          | from 7:11 a.m. and<br>observation from 9:<br>R102 had not been<br>observation on 1/14<br>assisted to toilet. R<br>stool, with a small a   | observations on 1/14/2015,<br>9:09 a.m. and continuous<br>:13 a.m. through 10:48 a.m.<br>assisted with toileting. During<br>4/15, at 11:22 a.m. R102 was<br>102 had been incontinent of<br>amount of soft non formed<br>and in the incontinence brief. |                     |  |                      |                         |
|                          | indicated the nursin<br>assignments to car<br>stated, "We just fre<br>During a second int<br>a.m. NA-E identified<br>a time schedule. No<br>would tell staff if he<br>bathroom. NA-E ve<br>R102 to be in his w  | terview on 1/14/15, at 10:42<br>d staff do not provide cares on<br>A-E further identified R102<br>needed to go to the<br>prified it was not unusual for<br>heelchair all morning. NA-E<br>d not assisted R102 to the                                   |                     |  |                      |                         |
|                          | R102 to be in his w<br>verified that she ha<br>toilet so far that mo  | heelchair all morning. NA-E<br>d not assisted R102 to the  |                     |  |                      |                         |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            |  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|---|----------------------------|--|--------------------------------|-------------------------|
|                          |   | 00679   | B. WING                    |  | 01/16/2015                     |                         |
|                          | PROVIDER OR SUPPLIER  |   | DRESS, CITY, S             | TATE, ZIP CODE   |                                | 10/2013                 |
|                          | KS LODGE  | 201 SHAI  | DY LANE DRIV<br>, MN 56482 |  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 840                    | Continued From pa   | ige 38  | 2 840                      |  |                                |                         |
|                          | NA-D indicated R102 would tell staff if he needed<br>to go to the bathroom. NA-D identified she<br>believed R102 was not on a toileting plan. NA-D<br>verified that she had not toileted R102 so far that<br>morning. |   |                            |  |                                |                         |
|                          | indicated R102 did<br>plan. NA-F identifie<br>and bladder, and a<br>go to the bathroom<br>NA-F indicated R10  | 1/14/15, at 11:06 a.m. NA-F<br>not have a scheduled toileting<br>d R102 was continent of bowel<br>t times knew if he needed to<br>or if he had been incontinent.<br>22 would usually be taken to<br>e morning. NA-F verified she<br>02.   |                            |  |                                |                         |
|                          | licensed practical n<br>nursing assistants<br>according to the nu<br>identified she believ  | on 1/14/15, at 11:10 a.m.<br>urse (LPN)-B verified the<br>provide care for the residents<br>rsing assistant sheets. LPN-B<br>ved R102 was continent of<br>and he would ask for<br>eting.  |                            |  |                                |                         |
|                          | registered nurse (F<br>assessed to be toi<br>the care plan. How<br>assistant care shee<br>missed." RN-B veri  | on 1/16/2015, at 10:11 a.m.<br>N)-B verified R102 was<br>leted every 2 hrs and it was on<br>ever, it was not on the nursing<br>et, "and that is why it was<br>fied the nursing assistant care<br>evised to reflect the need for<br>nours. |                            |  |                                |                         |
|                          | director of nursing<br>expect residents ca  | y on 1/16/15, at 11:31 a.m. the<br>(DON) verified she would<br>are to be performed as directed<br>essments and care plan.   |                            |  |                                |                         |
| mesota D                 | The director of nurs  | ETHOD FOR CORRECTION:<br>sing (DON) or designee could<br>nent policies and procedures   |                            |  |                                |                         |

|                          | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | E CONSTRUCTION ()  | (3) DATE SURVE<br>COMPLETED |  |
|--------------------------|--|--|---------------------------|--|-----------------------------|--|
|                          |  | 00679  | B. WING                   |  | 01/16/2015                  |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S           | STATE, ZIP CODE  |                             |  |
| AIR OA                   | KS LODGE   |  | DY LANE DR<br>A, MN 56482 | IVE  |                             |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)  | BE COMF                     |  |
| 2 840                    | Continued From pa  | ge 39  | 2 840                     |  |                             |  |
|                          | with toileting receiv<br>staff as appropriate<br>systems or audit to   | lents who require assistance<br>ve timely services; educate<br>e; then develop monitoring<br>ensure ongoing compliance.<br>to the Quality Assurance  |                           |  |                             |  |
|                          | TIME PERIOD FOR<br>(21) days.  | R CORRECTION: Twenty one   |                           |  |                             |  |
| 2 900                    | MN Rule 4658.052<br>Ulcers   | 5 Subp. 3 Rehab - Pressure   | 2 900                     |  | 2/16/                       |  |
|                          | comprehensive res of nursing services  | sores. Based on the<br>ident assessment, the director<br>must coordinate the<br>ursing care plan which   |                           |  |                             |  |
|                          | without pressure so<br>pressure sores unle<br>condition demonstr   | o enters the nursing home<br>ores does not develop<br>ess the individual's clinical<br>ates, and a physician<br>they were unavoidable; and   |                           |  |                             |  |
|                          | receives necessary   | ho has pressure sores<br>y treatment and services to<br>revent infection, and prevent<br>veloping.   |                           |  |                             |  |
|                          | by:<br>Based on observati<br>review, the facility f<br>identified at risk for<br>necessary care and<br>and prevent the dev | ent is not met as evidenced<br>ion, interview, and document<br>ailed to ensure residents<br>pressure ulcers received the<br>treatment to promote healing<br>velopment of further pressure<br>sident (R49, R102) in the |                           | Nursing staff will receive education of<br>care and pressure ulcer prevention<br>including following care guides for tu<br>schedules and on following resident<br>of care, including following their grou<br>assignments which they are to carry | ırning<br>s plan<br>ıp      |  |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                          | LE CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED        |
|--------------------------|---|--|--------------------------|--|-------------------|------------------------|
|                          |   | 00679  | B. WING                  |  | 01/16/2015        |                        |
| IAME OF F                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,             | STATE, ZIP CODE  |                   |                        |
|                          | KS LODGE  |  | DY LANE DF<br>, MN 56482 |  |                   |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | SHOULD BE         | (X5)<br>COMPLE<br>DATE |
| 2 900                    | Continued From pa   | age 40   | 2 900                    |  |                   |                        |
|                          | <ul> <li>2 900 Continued From page 40</li> <li>sample identified at risk for pressure ulcers.</li> <li>Findings include:</li> <li>R49's quarterly Minimum Data Set (MDS) dated 12/1/14, indicated R49 had diagnoses including peripheral vascular disease, diabetes, cerebrovascular accident (stroke), and hemiplegia. The MDS also indicated R49 was cognitively intact, required extensive assistance of 2 staff to physically help him with bed mobility, transfers, dressing, and toileting. R49 was identified at risk for developing pressure ulcers, and had 2 unstageable suspected deep tissue injuries in evolution (a pressure related injury to subcutaneous tissues under intact skin) and recommended R49 have a pressure relieving device to chair and bed.</li> <li>R49's current care plan dated 11/24/14, instructed staff to off load (relieve pressure) heels in bed and recliner, wear a left heel derma saver, have heel guards on in bed and recliner, weekly skin inspection, update physician on skin changes,</li> </ul> |  |                          | Group assignments reveal toileting,<br>repositioning and assistive devices<br>residents require.<br>LN will receive education on following plan<br>of care for residents with pressure ulcers.<br>DON/Designee will complete random<br>audits weekly for 3 months to assure<br>deficient practice has been corrected.<br>QAA will review results over the next 3<br>months to review for trends and any<br>deficient practice. |                   |                        |
|                          | turn and reposition<br>right AFO (foot dro<br>when in wheel cha<br>R49's Nurse Aid C<br>directed staff to us  | every 4 hours, and to wear<br>p brace) with transfers and  |                          |  |                   |                        |
|                          | Review of R49's N<br>11/26/14, from ger<br>documented: "The<br>tissue injury of his<br>length x 1 cm widt<br>intact on his left lat<br>were on and these  | ursing Home Notes dated<br>heral nurse practioner (GNP)<br>e staff noted that he has a deep<br>left lateral heel. He has a 2 cm<br>h purple blister area that is<br>teral heel. Shoes and socks<br>were removed. They are not<br>eet. Left lateral deep tissue |                          |  |                   |                        |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |  |  |
|--------------------------|---|--|-----------------------------|--|-----------------------------------|-------------------------|--|--|
|                          |   | 00679  | B. WING                     |  | 01/                               | 16/2015                 |  |  |
| VAME OF                  | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, ST            | TATE, ZIP CODE   |                                   |                         |  |  |
| AIR OA                   | KS LODGE  |  | DY LANE DRIV<br>A, MN 56482 | /E   |                                   |                         |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |  |
| 2 900                    | Continued From pa   | ige 41   | 2 900                       |  |                                   |                         |  |  |
|                          | assess the left heel  | off at this time. Continue to<br>I, off load it with gel boots,<br>and I will reassess it again  |                             |  |                                   |                         |  |  |
|                          | During observation of morning cares on 1/14/15,<br>at 7:05 a.m. nursing assistant (NA)-E and NA-F<br>were getting R49 dressed while he was sitting in<br>his recliner. After R49's shirt was on, NA-E<br>proceeded to assist R49 to do a pivot transfer into<br>his wheelchair. R49 was observed to have black<br>tennis shoes on both feet with no AFO brace to<br>his right foot. R49 was brought out of his room at<br>that time. At 8:00 a.m. R49 requested to return to<br>his room, and sat in his wheelchair until 8:48 a.m. |  |                             |  |                                   |                         |  |  |
|                          | room, and his feet of<br>rest of the recliner a<br>black tennis shoes<br>resident continued<br>GNP entered his ro<br>black tennis shoes   | ras sitting in his recliner in his<br>were elevated up on the foot<br>and continued to wear his<br>on his feet. At 9:02 a.m. the<br>to sit in his recliner and the<br>oom and proceeded to take the<br>off to look at his left heel GNF<br>lack scab approximately 2 cm<br>oot is good." |                             |  |                                   |                         |  |  |
|                          | was sitting in his re<br>on the foot rest of t  | on 1/15/15, at 3:30 p.m. R49<br>cliner, had his feet elevated up<br>he recliner. R49 had no shoes<br>saver boots were laying on his<br>feet.   |                             |  |                                   |                         |  |  |
|                          | Sore Risk dated 12  | e For Predicting Pressure<br>/16/14, indicated R49 had<br>ping pressure ulcers.  |                             |  |                                   |                         |  |  |
|                          | 11/25/14, indicated pressure on R49's   | ance Collection Sheet dated<br>skin issues related to<br>left heel, and indicated R49<br>theel off loaded with derma   |                             |  |                                   |                         |  |  |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            | CONSTRUCTION   |                                   | E SURVEY<br>PLETED       |
|--------------------------|---|---|----------------------------|--|-----------------------------------|--------------------------|
|                          |   | 00679   | B. WING                    |  | 01/                               | 16/2015                  |
| NAME OF I                | IE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE   |   |                            |  |                                   |                          |
| FAIR OA                  | KS LODGE  |   | OY LANE DRIN<br>, MN 56482 | /E   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 2 900                    | Continued From pa   | ge 42   | 2 900                      |  |                                   |                          |
|                          | savers on.  |   |                            |  |                                   |                          |
|                          | dated 1/14/15, direct<br>deep tissue injuries<br>for deep tissue inju<br>off, and to wear right   | ministration record (TAR)<br>cted staff to apply betadine to<br>/feet topically one time a day<br>ry to left heel until scab falls<br>at AFO with transfers and<br>. Observe for redness and              |                            |  |                                   |                          |
|                          | indicating the follow   | l Documentation Form<br>ving measurements of R49's<br>o his left outer heel:  |                            |  |                                   |                          |
|                          | width-contacted wo<br>12/10/14-length 2.3<br>blister with no drain<br>12/17/14-length 1.7<br>12/29/14-length 1.5<br>1/9/15- scabbed ov<br>measured  | centimeters (cm) x 1.2 cm<br>und nurse/next rounds.<br>cm x 1.3 cm width- fluid filled<br>age<br>c cm x 0.8 cm width<br>c cm x 0.5 cm width<br>er area (dry skin noted) not<br>o monitor per wound nurse, |                            |  |                                   |                          |
|                          | Reviewed R49's Pr<br>1/14/14:   | ogress Notes from 11/1/14 to  |                            |  |                                   |                          |
|                          | side heel, not open<br>discomfort, the area<br>applied heel guard<br>11/24/14- "Left oute<br>discoloration, occup<br>and said to continu-<br>in recliner and in be<br>we are also to off lo | er heel area intact purplish<br>pational therapy (OT) aware<br>e with derma save heel guards<br>ed. OT looked at area and said<br>pad heels when in bed and<br>ut on resident's care plan and             |                            |  |                                   |                          |

Minnesota Department of Health STATE FORM

|                          | ta Department of He<br>T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION   |                | E SURVEY<br>PLETED      |
|--------------------------|---|---|-----------------------------|--|----------------|-------------------------|
|                          |   | 00679   | B. WING                     |  | 01/            | 16/2015                 |
| IAME OF F                | ROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, ST             | TATE, ZIP CODE   |                |                         |
|                          | KS LODGE  |   | DY LANE DRIV<br>A, MN 56482 | /E   |                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | derma saver placed<br>folded blanket."<br>12/12/14- "Left hee<br>blackened, betading<br>and recliner and we<br>12/19/14- "Blister o<br>blister, dry, no infec<br>1/5/15-"Left outer h<br>1/12/15- "Left neel<br>infection, betadine<br>During interview on<br>stated R49 had dee<br>wearing his shoes i<br>R49 liked to sit in h<br>instructed to ensure<br>should not be wear<br>wearing gel boots.<br>During interview on<br>family member (FN<br>tissue injury on his<br>with his shoes on ir<br>During interview on<br>stated R49 was to b<br>his feet, should hav<br>over the foot rest of<br>NA-E stated this is<br>remember to do it."<br>During a follow up i<br>a.m. NA-E confirme<br>AFO brace to his rig<br>in his wheelchair. F | heel remains intact, fluid filled,<br>d and off loaded with use of<br>l site dry and intact,<br>e applied, off loading in bed<br>earing derma saver."<br>n right heel gone left out heel<br>stion, drainage, redness."<br>eel site unchanged."<br>site crusted and dry, no<br>treatment applied."<br>1/14/15, at 8:55 a.m. GNP<br>ep tissue injuries caused by<br>n the recliner. GNP stated<br>is recliner, and staff was<br>e R49 had his heels off loaded,<br>ing shoes, and should be<br>1/14/15, at 1:39 p.m. R49's<br>I)-F stated R49 got the deep<br>heel from crossing his feet<br>n the recliner.<br>1/14/15, at 2:00 p.m. NA-E<br>be wearing derma savers on<br>re his shoes off with his heels<br>f recliner and off load heels.<br>completed for R49, "When I<br>nterview on 1/15/15, at 10:36<br>ed R49 was to be wearing a<br>ght foot for transfers and while<br>R49 stated R49 had not been<br>race and she was not aware |                             |  |                |                         |
|                          | During interview on<br>partment of Health   | 1/15/15, at 10:45 a.m.  |                             |  |                |                         |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             |  |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|--|-----------------------------|--|-----------------------------------|-------------------------|
|                          |  | 00679  | B. WING                     |  | 01/                               | 16/2015                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, ST            | TATE, ZIP CODE   |                                   |                         |
| FAIR OA                  | KS LODGE   |  | DY LANE DRIN<br>A, MN 56482 | /E   |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | physical therapist a<br>was to wear a AFO<br>stated, "I am not su<br>PTA-A stated there<br>the AFO brace, so<br>it on.<br>During interview or<br>registered nurse (F<br>shoes should be of<br>should have gel bo<br>the AFO brace.<br>During interview or<br>of nursing (DON) c<br>for R49 instructed s<br>brace to his right for<br>the heel and while<br>have derma safer of<br>R102's quarterly M<br>the resident had dia<br>healing hip fracture<br>amputee, congestiv<br>chronic kidney dise<br>the resident had no | assistant (PTA)-A stated R49<br>brace to his right foot and<br>ure if he has been wearing it."<br>was an order for R49 to wear<br>nursing staff should be putting<br>1/15/15 at 11:20 a.m.<br>RN)-B confirmed that R49's<br>if when he is in the recliner,<br>ots on, and should be wearing<br>1/15/15, at 3:15 p.m. director<br>onfirmed the current care plan<br>staff R49 was to have a AFO<br>oot during transfer to protect<br>in his wheelchair, and was to<br>gel boots when in the recliner.<br>DS dated 12/16/14, identified<br>agnoses including depression,<br>e, right arm below the elbow<br>ve heart failure, fatigue, and<br>ease. The MDS also identified<br>o cognitive impairment and<br>assistance for all areas of | 2 900                       |  |                                   |                         |
|                          | 12/10/14, identified in the wheel chair a  | rance Collection Sheet dated<br>I R102 was able to be seated<br>and lay in bed for 2 hours<br>bony prominence's.   |                             |  |                                   |                         |
|                          | the resident had a<br>related to decrease<br>instructed to turn a<br>hours and as need   | e plan dated 12/8/14, identified<br>risk for skin break down<br>ed mobility, and staff was<br>nd reposition R102 every 2<br>ed, and to explain risks and<br>dent of allowing staff to assist   |                             |  |                                   |                         |

| STATEMEN                 | ta Department of He<br>T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             | CONSTRUCTION   |               | E SURVEY<br>PLETED      |
|--------------------------|---|--|-----------------------------|--|---------------|-------------------------|
|                          |   | 00679  | B. WING                     |  | 01/           | 16/2015                 |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, S             | TATE, ZIP CODE   |               |                         |
| FAIR OA                  | KS LODGE  |  | DY LANE DRIV<br>A, MN 56482 | VE   |               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | Continued From pa   | age 45   | 2 900                       |  |               |                         |
|                          | with changing inco<br>not to remain in we   | ntinent clothing and brief, and t clothing.  |                             |  |               |                         |
|                          | R102 was not repo<br>hours on 1/14/2015   | sitioned for greater than 4<br>5.  |                             |  |               |                         |
|                          | 1/14/2015, the follo<br>7:11 a.m. R102 wa<br>wheel chair.<br>7:49 a.m. R102 re<br>the dining room.<br>8:17 a.m. R102 wa<br>room and remained<br>being repositioned.<br>8:54 a.m. R102 va<br>room for an activity<br>wheelchair and<br>8:57 a.m. R102 wa<br>room for an activity<br>wheelchair.<br>9:09 a.m. R102 ren<br>wheel chair.<br>10:25 a.m. R102 ren<br>wheel chair.<br>10:48 a.m. NA-D po<br>by the nurses statio<br>R102 had not been<br>During interview on | nained in the television area in<br>had not been repositioned.<br>s brought to the edge of the<br>r and remained in the<br>mained in the activity in his<br>emained seated in the<br>d not been repositioned.<br>ushed R102 to the dining area<br>on and provided R102 a snack<br>repositioned since 7:11 a.m. |                             |  |               |                         |
|                          | stated the nursing a  | assistants did not have<br>re for specific residents, and  |                             |  |               |                         |
|                          | 10:42 a.m. NA-E st<br>cares on a time scl<br>R102 was on a rep<br>stated R102 was o   | interview on 01/14/2015, at<br>tated staff did not provide<br>nedule, and she was not aware<br>ositioning schedule. NA-E<br>ften in his wheel chair all<br>ted she was not aware if R102<br>ned that morning.  |                             |  |               |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             | (X2) MULTIPLE CONSTRUCTION A. BUILDING:                                       |                                   | E SURVEY<br>PLETED      |
|--------------------------|--|--|-----------------------------|---|-----------------------------------|-------------------------|
|                          |  | 00679  | B. WING                     |   | 01/                               | 16/2015                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, ST            | TATE, ZIP CODE  |                                   |                         |
| FAIR OA                  | KS LODGE   |  | DY LANE DRIV<br>A, MN 56482 | /E  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | Continued From pa  | ge 46  | 2 900                       |   |                                   |                         |
|                          | NA-D stated R102 stand and/ or be rep  | 1/14/2015, at 10:51 a.m.<br>would tell staff if he needed to<br>positioned, and she believed<br>repositioning schedule.  |                             |   |                                   |                         |
|                          | NA-F stated R102 or<br>repositioning plan, I<br>him to the bathroon                    | 1/14/2015, at 11:06 a.m.<br>did not have a scheduled<br>out staff would usually take<br>n in the morning around 10:00-<br>ted she had not assisted R102<br>ositioning.                   |                             |   |                                   |                         |
|                          | stated R102's curre required extensive   | 1/14/2015, 11:13 a.m. RN-B<br>ent care plan indicated R102<br>assistance with repositioning,<br>to reposition the resident   |                             |   |                                   |                         |
|                          | RN-B and NA-F we toileting. NA-B and and transfer to the                               | on 1/14/2015, at 11:22 a.m.<br>re asked to assist R102 with<br>NA-F assisted R102 to stand<br>toilet. R102's skin on his<br>, but wrinkled and creased.                                  |                             |   |                                   |                         |
|                          | RN-B stated R102<br>repositioned every a<br>assistant care shee<br>used to provide car | 1/16/2015, at 10:11 a.m.<br>was assessed to be<br>2 hrs, however, the nursing<br>it (identified as what the NAs<br>es to residents) did not<br>and reposition every two<br>in breakdown. |                             |   |                                   |                         |
|                          | DON stated R102 s<br>and/or repositioned   | 1/16/2015, at 11:31 a.m. the<br>should have been toileted<br>every 2 hours, and stated the<br>have gone over 4 hours<br>ositioning.  |                             |   |                                   |                         |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                          | CONSTRUCTION   |                              | E SURVEY<br>PLETED       |
|--------------------------|---|--|--------------------------|--|------------------------------|--------------------------|
|                          |   | 00679  | B. WING                  |  | 01/                          | 16/2015                  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AL  | DRESS, CITY, ST          | TATE, ZIP CODE   |                              |                          |
| FAIR OA                  | KS LODGE  |  | DY LANE DRI\<br>MN 56482 | /E   |                              |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 900                    | The facility policy tit<br>Integrity/Wound Ma<br>9/13/2011, identified<br>Residents with risk<br>integrity will receive<br>treatment/services,<br>determined to be at<br>skin integrity, will re<br>treatment/services<br>or "off-loading" as p<br>care plan.<br>A SUGGESTED ME<br>The director of nursi<br>develop and implem<br>to ensure that resid<br>pressure ulcers rec<br>staff as appropriate<br>systems or audit to<br>Report the findings<br>Committee. | led Pressure Ulcers/Skin<br>nagement-HDGR dated<br>d Treatment/ Management;<br>for or who have a loss of skin  | 2 900                    |  |                              |                          |
| 21915                    | Residents of HC Fa  | -  | 21915                    |  |                              | 2/16/15                  |
|                          | their families shall h<br>maintain, and partic<br>family councils. Ea<br>assistance and spa<br>meetings shall be a<br>visitors attending or<br>invitation. A staff por<br>responsibility of pro   | ry councils. Residents and<br>have the right to organize,<br>sipate in resident advisory and<br>ch facility shall provide<br>ce for meetings. Council<br>(fforded privacy, with staff or<br>hly upon the council's<br>erson shall be designated the<br>viding this assistance and<br>en requests which result from |                          |  |                              |                          |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                          | LE CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED         |
|--------------------------|--|---|--------------------------|---|-------------------|-------------------------|
|                          |  | 00679   | B. WING                  |   | 01/1              | 6/2015                  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY,             | STATE, ZIP CODE   |                   |                         |
| AIR OA                   | KS LODGE   |   | DY LANE DR<br>, MN 56482 | IVE   |                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHC<br>CROSS-REFERENCED TO THE APPP<br>DEFICIENCY)                         | ULD BE            | (X5)<br>COMPLET<br>DATE |
| 21915                    | Continued From pa  | ige 48  | 21915                    |   |                   |                         |
|                          | shall be encourage   | council meetings. Resident and family councils<br>shall be encouraged to make recommendations<br>regarding facility policies.   |                          |   |                   |                         |
|                          | by:<br>Based on interview  | ent is not met as evidenced<br>, the facility failed to attempt<br>council at least on an annual  |                          | SW/Designee will hold Family C<br>meetings at least bi-annually, ar<br>residents families by placing a le<br>admission packets. | nd inform         |                         |
|                          | Findings include:  |   |                          | QAA will receive minutes from SW<br>regarding Family Council meetings to<br>discuss and resolve any concerns at<br>bi-annually. |                   |                         |
|                          | social services (SS<br>family council. SS-<br>yet attempted to or<br>had no knowledge<br>attempted prior. SS<br>begin that process | on 1/13/15, at 4:07 p.m.,<br>)-A was interviewed regarding<br>A indicated that she had not<br>ganize a family council, and<br>of a family council having been<br>S-A stated she had plans to<br>in April 2015. SS-A verified<br>ed any residents or families of |                          |   |                   |                         |
|                          | family member (FN<br>any information reg<br>however, would be  | r on 1/15/15, at 11:23 a.m. a<br>I)-A stated he had not received<br>larding a family council group;<br>interested in becoming a<br>ber when one was organized.  |                          |   |                   |                         |
|                          | the director of nursi  | v on 1/16/201, at 11:41 a.m.<br>ing (DON) verified a family<br>e been attempted at least one<br>ar.   |                          |   |                   |                         |
|                          | Administrator and S<br>policies to include a<br>council on at least a<br>Assurance Commit  | HOD OF CORRECTION: The<br>Social Worker could develop<br>an attempt to organize family<br>a yearly basis. The Quality<br>tee could develop a system to<br>ts made at forming a family   |                          |   |                   |                         |

| STATEMEN<br>AND PLAN     | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                               | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED     |                         |
|--------------------------|--|---|---|--|-----------------------------------|-------------------------|
|                          |  |   | A. BUILDING: _                          | ·····  |                                   |                         |
|                          |  | 00679   | B. WING                                 |  | 01/                               | 16/2015                 |
| NAME OF                  | PROVIDER OR SUPPLIER                                     |   | DDRESS, CITY, ST                        |  |                                   |                         |
| FAIR OA                  | KS LODGE   |   | DY LANE DRIV<br>A, MN 56482             | /E   |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21915                    | Continued From pa  | ge 49   | 21915                                   |  |                                   |                         |
|                          | council.   |   |   |  |                                   |                         |
|                          | (21) days.   | R CORRECTION: Twenty-one  |   |  |                                   |                         |
|                          |  |   |   |  |                                   |                         |