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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QMWJ

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

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

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

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

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

6. DATE OF SURVEY **04/10/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Beth Nowling, HFE NEII — 04/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 05/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/04/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/03/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

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 completd 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 monirtoring 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.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245581	A. Building B. Wing	4/10/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**04/06/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**04/06/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/mm	04/20/2015	34088	04/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/16/2015			

AH Form Approved

4/20/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00679	A. Building B. Wing	4/10/2015

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

This report is completed by a 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	04/06/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/mm	04/20/2015	34088	04/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/16/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QMWJ

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245581**

2.STATE VENDOR OR MEDICAID NO.
(L2) **719475700**

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

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

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

6. DATE OF SURVEY **03/11/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 03/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 04/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/16/2015 Co.
DETERMINATION APPROVAL

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/03/2015
(L33)

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.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On April 10, 2015,

I, STEFAN STAMENKOVIC, ADMIN DESIGNEE, 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: STEFAN STAMENKOVIC, ADMIN DESIGNEE, Date 4/10/15
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On April 10, 2015,

I, Beth Nowling, RN, LOC Health Regulator of the 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 Stefan Stamenkovic,
(Name)(Please Print)
Admin Designee, Date 4/10/15
(Title)(Please Print)

Signed: [signature], RN, LOC Health Reg, Date 4/10/15
(Name)(Please Print) (Title)(Please Print)

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

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

origpaltr

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

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

origpaltr

MINNESOTA MDH DEPARTMENT OF HEALTH

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	R 03/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 3/11/15. The certification tags that were corrected can be found on the CMS2567B. Also there is a tag that was not found corrected and a new tag was also issued at the time of the PCR which is located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	{F 279}		4/6/15

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

Electronically Signed | 03/19/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	R 03/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 279}	Continued From page 1 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and ensure written care plan interventions were developed for 1 of 1 resident (R49) in the sample who had dysphagia (difficulty swallowing) and speech therapy recommendations when eating. Findings include: R49's Admission Record dated 3/10/15, identified R49 had diagnoses of contracture of the hands, history of cerebral infarct (stroke) type II diabetes and malaise and fatigue. R49's quarterly Minimum Data Set (MDS) dated 12/1/14, indicated R49 had very little cognitive impairment and had trouble with coughing or choking during meals. On 3/10/15, at 5:24 p.m. during the evening meal, R49 was observed to be served a meat and cheese sandwich, which was a special request. A visitor was observed to assist R49 to eat the meal by holding the sandwich in her bare hands and bringing it to R49's mouth. The visitor assisted R49 to quickly eat the sandwich and R49 independently drank 100% of all the fluid that was provided.	{F 279}	F279 Resident #49 suffered no ill effects from being assisted by a visitor at meal time. Resident #49 has had his Care Plan reviewed and revised to reflect SLP recommendations and swallowing disorders. Any resident needing assistance with meals has the potential to be affected by this practice. *Nursing staff is to receive education on not allowing visitors to feed/assist residents with meals *DON/Designee will update/review all Care Plans of current residents with specialized feeding programs that recommendations are appropriately included into Care Plan *DON/Designee will assure process is completed and will audit Care Plans weekly x 3months to assure system is intact *Findings from audits will be reviewed at QAA x 3 months to assure trends or negative findings of audits are corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	R 03/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 279}	Continued From page 2 R49's speech therapy progress notes and assessment dated 10/17/14, revealed R49 had an acute CVA (stroke) and was hospitalized on 10/9/14. While at the hospital R49 had a video swallow completed which indicated "mod-severe oral pharyngeal dysphagia characterized by poor bolus control in oral cavity with pooling in the valleculae. Decreased hyolaryngeal elevation. Pt had silent aspiration of thin liquids, nectar thick liquids, and honey thick liquids. With pudding thick liquids pt had penetration with no cough noted. Upon R49's readmission to the nursing home R49 participated in speech therapy until 11/12/14. Review of a Residential Referral Interdepartmental Communication form dated 11/12/14, from PRO REHAB to nursing and dietary departments the following was identified: "Pt had made the educated decision to return to regular texture /thin liquids. Pt is not to eat and drink unsupervised. When assisting with feeding: 1. Provide small bites/sips one at a time at a slow rate 2 Ensure pt has swallowed prior to offering another bite/drink. During interview with the speech language pathologist (SLP) on 03/11/2015, at 8:30 a.m. she stated R49 had an acute CVA in October 2014 , and as a result of this stroke R49 silently aspirated food and liquids. The SLP stated that she worked with R49 post hospitalization and did exercises to help increase swallowing ability. The SLP stated that R49 should be assisted to eat according to the written instructions she had provided the nursing and dietary staff. The SLP	{F 279}	Corrective Action is to be completed by: 4/6/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	R 03/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 279}	Continued From page 3 stated that she was not aware that R49 had been using straws to drink from, and that using a straw was contraindicated for the type of swallowing deficits R49 experienced. The SLP stated that she had not provided R49 with education regarding the risk of using straws because she was not aware staff were providing R49 with straws to drink through. R49's care plan dated 3/10/15, lacked identification that R49 had any swallowing problems and had not included the SLP instructions for assisting R49 to eat (1. Provide small bites/sips one at a time at a slow rate 2. Ensure pt has swallowed prior to offering another bite/drink.) The director of nursing (DON) was interviewed on 3/10/15, at 7:19 p.m. and confirmed R49's care plan had not included interventions written by the SLP regarding assisting R49 with eating nor the dysphagia diagnosis.	{F 279}		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		4/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	R 03/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 Based on observation, interview and document review, the facility failed to ensure that trained staff assisted during dinning according to the speech therapy recommendations for 1 of 1 resident (R49) in the sample who had dysphagia (difficulty swallowing) and was observed to be assisted to eat by a visitor. Findings include: R49's Admission Record dated 3/10/15, indicated R49 had diagnoses of contracture of the hands, history of cerebral infarct (stroke), type II diabetes, malaise and fatigue. R49's quarterly Minimum Data Set (MDS) dated 12/1/14, revealed R49 had very little cognitive impairment and had trouble with coughing or choking during meals. On 3/10/15, at 5:24 p.m. during the evening meal, R49 was observed to have limited range of motion in both upper extremities and two large adaptive plastic glasses filled with chocolate milk and juice with straws inserted. R49 was observed to drink independently by bending over and sucking up the fluid through the straw without having to pick up the glass and hold it. R49 was served a meat and cheese sandwich, which was a personal request. A visitor was observed to hold R49's sandwich in her bare hands, bringing it to R49's mouth allowing him to eat it. With the visitor holding the sandwich, R49 was observe to quickly eat the sandwich and independently drink 100% of all the fluid provided.	F 323	F323 Resident #49 suffered no ill effects from being assisted by a visitor at meal time. Visitor will no longer feed resident #49 and resident□s Care Plan has been reviewed and revised to reflect SLP recommendations for specific feeding cues. All resident requiring assistance with feeding has the potential to be affected by this practice. *Nursing staff is to receive education on not allowing visitors to feed/assist residents with meals *Visitor was educated on not being able to feed family member or other residents without skilled training *Any family members that wish to assist their own family member with meals will have education completed to assure they understand risk and benefits of feeding their family member and have a skilled check off by an RN or Speech Therapist *Audits will take place 3 times/week to assure that a system is in place to assure staff education was effective *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: 4/6/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	R 03/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 On 3/10/15, at 5:30 p.m. the visitor stated she had frequently assisted R49 to eat his evening meal because she thought it was helpful to the facility nursing assistants and also helped R49 because he was assisted sooner than if he had to wait for a nursing assistant to assist him. The visitor also stated that she had not been trained to assist R49 with eating. On 3/10/15, at 6:01 p.m. the visitor stated she had assisted R49 to eat dinner approximately four days per week. She stated R49 had a good appetite and was a " quick " eater with " no stopping him. " The visitor also stated approximately twice a week R49 would act like he was " choking " after drinking liquids too fast and like it went down the wrong tube. In addition, the visitor stated she had not received training or instruction on how to assist R49 to eat. R49's speech therapy progress notes and assessment dated 10/17/14, revealed R49 had an acute CVA (stroke) and was hospitalized on 10/9/14. While at the hospital R49 had a video swallow completed which indicated "mod-severe oral pharyngeal dysphagia characterized by poor bolus control in oral cavity with pooling in the valleculae. Decreased hyolaryngeal elevation. Pt had silent aspiration of thin liquids, nectar thick liquids, and honey thick liquids. With pudding thick liquids pt had penetration with no cough noted. Upon R49's readmission to the nursing home R49 participated in speech therapy until 11/12/14.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	R 03/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 Review of a Resident Referral Interdepartmental Communication dated 11/12/14, from PRO REHAB to nursing and dietary departments the following was identified: "Pt had made the educated decision to return to regular texture /thin liquids. Pt is not to eat and drink unsupervised. When assisting with feeding: 1. Provide small bites/sips one at a time at a slow rate 2 Ensure pt has swallowed prior to offering another bite/drink. Review of a Resident Referral Interdepartmental Communication form dated 11/3/14, from PRO REHAB to nursing and dietary departments indicated R49 and his wife made the informed decision for a diet change to puree textures/thin liquids. Risk and benefit form had been signed. On 3/11/15, at 8:30 a.m. the speech language pathologist (SLP) stated R49 had an acute CVA in October 2014, and as a result of this stroke R49 silently aspirated food and liquids. The SLP stated she worked with R49 post hospitalization and did exercises to help increase swallowing ability. The SLP stated she had recommended a follow-up video swallow study to advance R49 on his diet but R49 chose to forego the video swallow study and return to a normal diet. The SLP stated she had provided much education regarding the risks of advancing the diet without doing a video swallow first. The SLP stated R49 should be assisted to eat according to the written instructions she had provided the nursing and dietary staff. The SLP stated she was not aware R49 had been using straws to drink from and that using a straw was contraindicated for the type of swallowing deficits R49 experienced. The SLP	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	R 03/11/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 stated she had not provided R49 with education regarding the risk of using straws because she was not aware staff were providing R49 with straws to drink through. R49's care plan dated 3/10/15, was reviewed and it did had not identified R49's dysphagia diagnosis nor any swallowing problems and had not included the SLP instructions for assisting R49 to eat (1. Provide small bites/sips one at a time at a slow rate 2. Ensure pt has swallowed prior to offering another bite/drink.) On 3/10/15, at 7:19 a.m. the director of nursing (DON) stated she was not aware that a visitor was assisting R49 to eat during the evening meal, on most days. The DON confirmed that this visitor had not been trained to assist R49 with eating, and the care plan had not included interventions written by the SLP regarding assisting R49 with eating.	F 323		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245581	A. Building B. Wing	3/11/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/16/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/16/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **02/16/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **02/16/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/mm	03/16/2015	28035	03/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/16/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245581	A. Building B. Wing **01 - DINING ADDITION 01**	2/26/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0052	**02/16/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	03/16/2015	27200	02/26/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
2/6/2015	

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00679	A. Building B. Wing	3/11/2015

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

This report is completed by a 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) Item	(Y5) Date
ID Prefix **20302** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **02/16/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **02/16/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **02/16/2015**
ID Prefix **20840** Reg. # **MN Rule 4658.0520 Subp. 2 B** LSC	Correction Completed **02/16/2015**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **02/16/2015**	ID Prefix **21915** Reg. # **MN St. Statute 144.651 Subd. 2** LSC	Correction Completed **02/16/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/mm	04/09/2015	28035	03/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/16/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QMWJ

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245581**

2.STATE VENDOR OR MEDICAID NO.
(L2) **719475700**

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

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

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

6. DATE OF SURVEY **01/16/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 02/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/03/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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.

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.

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

5581s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable electronic POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		2/16/15

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

Electronically Signed | 02/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 by: Based on interview and document review, the facility failed to develop a comprehensive care plan that included the daily use of Remeron (an antidepressant medication) and a PRN (as needed) order for Ativan (an antianxiety medication) for 1 of 5 residents (R31) reviewed for unnecessary medications. Findings include: R31 was admitted to the facility 3/25/14. Diagnosis identified on the Order Summary Report included anxiety, adult failure to thrive and other personality disorder. The Order Summary Report also identified that R31 received Remeron 7.5 mg (milligrams), at bedtime to increase appetite, decrease anxiety and help to sleep, as well as Ativan 0.5 mg three times per day PRN for anxiety or sleep. The Minimum Data Set (MDS) dated 12/12/14, did not identify a BIMS score (brief interview for mental status) for cognition. The PPS (prospective payment system) MDS dated August 28, 2014, identified a BIMS of 8 indicating moderately impaired cognition. Review of the medication administration records (MAR) for October, November and December 2014, and January 2015, indicated that R31 took Ativan twice in October, nine times in November, four times in December and 5 times in January (through 1/14/15). Review of the behavior charting in the nurses notes identified anxious behaviors occurred almost daily. The facility care plan created on 6/27/14, identified mood/behaviors of verbally abusive	F 279	Resident #31 suffered no ill Effects from not having Remeron and Ativan on his care plan. Resident # 31 has had care plan reviewed and revised to reflect the use of Remeron and Ativan. All residents on antianxiety and antidepressants have the potential to be affected by the practice. SW, MDS Coordinator and Nurse managers will receive education on completing care plans that include incorporating these classes of medications in their care plans. SW, and NM will update all care plans to assure the class of medication in included in current care plans and MDS/SW will develop care plans for all new admissions. DON/Designee will assure process is completed and will audit care plans weekly x 3 moths to assure system is intact. Findings from audits will be reviewed at QAA x 3 months to assure trends or negative findings of audits are corrected. Corrective Action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 behaviors related to ineffective coping skills and poor impulse control. Non pharmacological interventions of monitor and anticipate resident's needs, monitor every shift and document observed behavior and attempted interventions in behavior log, monitor resident's understanding of the situation and allow time for the resident to express himself, provide positive feedback for good behavior and emphasize the positive aspects of compliance, when he becomes agitated intervene before agitation escalates, guide away form source of distress, engage calmly in conversation. The use of the Remeron and Ativan were not addressed on the care plan. During interview with the director of nursing on 1/14/15, at 2:30 p.m. she verified that the medications were not addressed on the care plan and that she would expect them to be.	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the written plan of care for 2 of 2 residents (R49, R102) reviewed at risk for pressure ulcers, for 1 of 2 resident (R102) who required assistance with toileting, and for 1 of 3 residents (R51) reviewed for non-pressure related skin conditions. Findings include:	F 282	No negative affects to resident @#49, #51 and #102 have been noted due to deficient practice. Resident #49, #51 and #102 have been assessed by an RN and care plan reviewed. Any resident requiring assistance with ADL's and assistive devices may be affected by this practice.	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 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. 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, turn and reposition every 4 hours, and to wear right AFO (foot drop brace) with transfers and when in wheel chair. R49's Nurse Aid Care Plan dated 1/15/15, directed staff to use derma savers to left heel while in recliner and bed and off load heels with pillow. During observation of morning cares on 1/14/15, at 7:05 a.m. nursing assistant (NA)-E and NA-F were getting R49 dressed while he was sitting in his recliner. After R49's shirt was on, NA-E proceeded to assist R49 to do a pivot transfer into his wheelchair. R49 was observed to have black tennis shoes on both feet with no AFO brace to his right foot. R49 was brought out of his room at that time.	F 282	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, repositioning and assistive devices residents require. LN have received education on following plan of care for residents with pressure and non-pressure related skin conditions. LN will update care plans and group assignment sheets PRN, regarding residents cares. 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. 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. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4	F 282		

At 8:48 a.m. R49 was sitting in his recliner in his room, and his feet were elevated up on the foot rest of the recliner and continued to wear his black tennis shoes on his feet. At 9:02 a.m. the resident continued to sit in his recliner and the GNP entered his room and proceeded to take the black tennis shoes off to look at his left heel GNP stated R49 had a black scab approximately 2 cm x 1 cm and "right foot is good."

During observation on 1/15/15, at 3:30 p.m. R49 was sitting in his recliner, had his feet elevated up on the foot rest of the recliner. R49 had no shoes on, and the derma saver boots were laying on his bed and not on his feet.

R49's Tissue Tolerance Collection Sheet dated 11/25/14, indicated skin issues related to pressure on R49's left heel, and indicated R49 was to have his left heel off loaded with derma savers on.

During interview on 1/14/15, at 8:55 a.m. GNP stated R49 had deep tissue injuries caused by wearing his shoes in the recliner. GNP stated R49 liked to sit in his recliner, and staff was instructed to ensure R49 had his heels off loaded, should not be wearing shoes, and should be wearing gel boots.

During interview on 1/14/15, at 2:00 p.m. NA-E stated R49 was to be wearing derma savers on his feet, should have his shoes off with his heels over the foot rest of recliner and off load heels. NA-E stated this is completed for R49, "When I remember to do it."

During a follow up interview on 1/15/15, at 10:36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5	F 282		

a.m. NA-E confirmed R49 was to be wearing a AFO brace to his right foot for transfers and while in his wheelchair. R49 stated R49 had not been wearing the AFO brace and she was not aware where the brace was at.

During interview on 1/15/15, at 10:45 a.m. physical therapist assistant (PTA)-A stated R49 was to wear a AFO brace to his right foot and stated, "I am not sure if he has been wearing it." PTA-A stated there was an order for R49 to wear the AFO brace, so nursing staff should be putting it on.

During interview on 1/15/15 at 11:20 a.m. registered nurse (RN)-B confirmed that R49's shoes should be off when he is in the recliner, should have gel boots on, and should be wearing the AFO brace.

During interview on 1/15/15, at 3:15 p.m. director of nursing (DON) confirmed the current care plan for R49 instructed staff R49 was to have a AFO brace to his right foot during transfer to protect the heel and while in his wheelchair, and was to have derma safer gel boots when in the recliner.

R102 was not assisted with repositioning according to the plan of care.
R102's quarterly MDS dated 12/16/14, identified the resident had diagnoses including depression, healing hip fracture, right arm below the elbow amputee, congestive heart failure, fatigue, and chronic kidney disease. The MDS also identified the resident had no cognitive impairment and required extensive assistance for all areas of daily living except eating.

R102's Tissue Tolerance Collection Sheet dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 12/10/14, identified R102 was able to be seated in the wheelchair and lay in bed for 2 hours without redness to bony prominence's. R102's current care plan dated 12/8/14, identified the resident had a risk for skin break down related to decreased mobility, and staff was instructed to turn and reposition R102 every 2 hours and as needed, and to explain risks and benefits to the resident of allowing staff to assist with changing incontinent clothing and brief, and not to remain in wet clothing. During continuous observation of R102 on 1/14/2015, the following was observed: 7:11 a.m. R102 was seated in the hallway in a wheel chair. 7:49 a.m. R102 remained in his wheelchair in the dining room. 8:17 a.m. R102 was brought to the television room and remained in his wheelchair without being repositioned. 8:54 a.m. R102 remained in the television area in the wheelchair and had not been repositioned. 8:57 a.m. R102 was brought to the edge of the room for an activity and remained in the wheelchair. 9:09 a.m. R102 remained in the activity in his wheel chair. 10:25 a.m. R102 remained seated in the wheelchair and had not been repositioned. 10:48 a.m. NA-D pushed R102 to the dining area by the nurses station and provided R102 a snack. R102 had not been repositioned since 7:11 a.m. During interview on 1/14/15, at 10:32 a.m. NA-E stated the nursing assistants did not have assignments to care for specific residents, and stated it was, "Just free for all."	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 During a follow up interview on 01/14/2015, at 10:42 a.m. NA-E stated staff did not provide cares on a time schedule, and she was not aware R102 was on a repositioning schedule. NA-E stated R102 was often in his wheel chair all morning. NA-E stated she was not aware if R102 had been repositioned that morning. During interview on 1/14/2015, 11:13 a.m. RN-B stated R102's current care plan indicated R102 required extensive assistance with repositioning, and instructed staff to reposition the resident every two hours. During observation on 1/14/2015, at 11:22 a.m. RN-B and NA-F were asked to assist R102 with toileting. NA-B and NA-F assisted R102 to stand and transfer to the toilet. R102's skin on his buttocks was intact, but wrinkled and creased. During interview on 1/16/2015, at 10:11 a.m. RN-B stated R102 was assessed to be repositioned every 2 hrs, however, the nursing assistant care sheet (identified as what the NAs used to provide cares to residents) did not instruct staff to turn and reposition every two hours to prevent skin breakdown. During interview on 1/16/2015, at 11:31 a.m. the DON stated R102 should have been repositioned every 2 hours, and stated the resident should not have gone over 4 hours without repositioning. R102 was not provided timely assistance with toileting according to the plan of care. R102's diagnoses included healing hip fracture, right arm below the elbow amputee, and chronic kidney disease. R102's quarterly MDS dated	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 8	F 282		

12/16/14, identified R102 was cognitively intact. The quarterly MDS also identified R102 required extensive assistance for toileting. R102's current care plan dated to be revised 12/8/14, identified he required toileting every two hours and as needed. R102 was to be checked and changed if already incontinent.

During intermittent observations on 1/14/2015, from 7:11 a.m. and 9:09 a.m. and continuous observation from 9:13 a.m. through 10:48 a.m. R102 had not been assisted with toileting. During observation on 1/14/15, at 11:22 a.m. R102 was assisted to toilet. R102 had been incontinent of stool, with a small amount of soft non formed stool on his bottom and in the incontinence brief.

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."

During a second interview on 1/14/15, at 10:42 a.m. NA-E identified staff do not provide cares on a time schedule. NA-E further identified R102 would tell staff if he needed to go to the bathroom. NA-E verified it was not unusual for R102 to be in his wheelchair all morning. NA-E verified that she had not assisted R102 to the toilet so far that morning.

During an interview on 1/14/15, at 10:51 a.m. NA-D indicated R102 would tell staff if he needed to go to the bathroom. NA-D identified she believed R102 was not on a toileting plan. NA-D verified that she had not toileted R102 so far that morning.

During interview on 1/14/15, at 11:06 a.m. NA-F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 9 indicated R102 did not have a scheduled toileting plan. NA-F identified R102 was continent of bowel and bladder, and at times knew if he needed to go to the bathroom or if he had been incontinent. NA-F indicated R102 would usually be taken to the bathroom in the morning. NA-F verified she had not toileted R102. During an interview on 1/16/2015, at 10:11 a.m. RN-B verified R102 was assessed to be toileted every 2 hrs and it was on the care plan. However, it was not on the nursing assistant care sheet, "and that is why it was missed." RN-B verified the nursing assistant care sheets had been revised to reflect the need for toileting every two hours. During an interview on 1/16/15, at 11:31 a.m. the DON verified she would expect residents care to be performed as directed by the resident assessments and care plan. R51's skin condition was not assessed, monitored or documented according to the care plan. The care plan dated, 3/17/10, directed staff to observe skin with routine daily care, and to report to nurse any changes noted, and to observe for bruising as it is a potential side effect of aspirin therapy. The care plan also directed staff to complete weekly skin inspection with documentation of results. The quarterly MDS dated 12/29/14, indicated R51 was cognitively intact and required assistance for all activities of daily living. The MDS indicated R51 had diagnoses which included degenerative joint disease, edema, Parkinson's, diabetes mellitus (DM) and osteoarthritis.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10	F 282		

During observation on 1/13/15, at 3:36 p.m. R51 was seated in a wheelchair next to the bed. Observed one large dark purple bruise, approximately 3 x 3 inches on the resident's right forearm, also observed 3 smaller dark purple bruises on resident's left hand and 1 small bruise on resident's left forearm. R51 stated the bruise on the right forearm happened a couple of days ago when her arm bumped the grab bar on the bed. R51 stated the bruises on the left arm and hand also happened a couple days ago and were caused when staff assist her left arm up to the grab bar next to the toilet. R51 stated staff grab her shirt to assist her left arm up to the toilet and by accident get her skin in with her clothes. R51 reported that she does take a daily aspirin and bruises easily. R51 stated she had not told staff about the bruises, then stated she was sure staff had seen the bruises because they help her get dressed and undressed everyday.

During medical record review, no documentation was evident to indicate R51 had bruises on the right and left forearms and left hand.

Skin assessment dated 9/29/14, indicated R51 was at risk for skin breakdown related to limited mobility, DM, edema, peripheral vascular disease and bladder incontinence. The skin assessment directed licensed staff to complete weekly skin assessments.

During interview on 1/14/15, at 9:57 a.m. NA-B confirmed she assisted R51 with daily cares including dressing on 1/14/15. NA-B reported R51 has real thin skin and staff have to be very careful when moving her arms. NA-B stated she did not notice any new bruises, but did state R51

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 11	F 282		

had black and blue bruises on both arms and hands. NA-B reported the nurses all know about those bruises on R51's arms and hands. When asked if NA-B had reported the bruises to the nurses, she stated, no because the resident has always had those bruises on her skin ever since she came here to this facility.

During interview on 1/14/15, at 9:59 a.m. LPN-A reported R51 bruises very easily, but could not confirm if R51 currently had any bruises without reviewing the medical record. LPN-A confirmed she was the nurse for R51 on 1/14/15. LPN-A stated staff would monitor bruises by documenting bruises in the progress notes on the resident's bath days. LPN-A reviewed R51's progress notes, and LPN-A reported the last progress note documented was on 1/2/15, and indicated no concerns to body surface at that time. LPN-A stated R51's last weekly skin inspection would have been on 1/9/15 (R51's bath day) and confirmed that the weekly skin assessment documentation was missing in the record related to skin condition. LPN-A confirmed no staff had reported R51 having any bruising to hands or arms. LPN-A stated she does not work with R51 consistently, and works all three floors.

During interview on 1/14/15, at 12:47 p.m. the DON stated staff are expected to observe for bruising during daily cares and report bruises to nurses right away so the nurse can assess and monitor the bruise in the progress notes until resolved. The DON confirmed staff are expected to follow the care plan which included documenting results of weekly skin inspections.

Review of the facility's Care Plans-Comprehensive policy dated April 1, 2008,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 12 indicated the care plans are designed to meet the resident's medical, nursing, mental and psychosocial needs, as identified in the comprehensive assessments.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess pain and implement interventions to relieve moderate to severe pain following a surgical procedure to the lower back for 1 of 1 resident (R83) reviewed for pain, and failed to monitor skin condition for 1 of 1 resident (R51) reviewed with multiple bruises. This deficient practice caused actual harm to R83. Findings include; R83's admission Minimum Data Set (MDS) dated 10/31/14, identified R83 had diagnoses which included arthritis, other specific rehabilitation procedure, malaise and fatigue, and difficulty walking. The MDS identified R83 had severe cognitive impairment and required extensive assistance for activities of daily living (ADLs). Further, the MDS identified R83 had occasional, moderate pain, received scheduled pain	F 309	Resident #83 has been assessed by his physician and has had his care plan updated and revised. The Medical Director is aware of the resident's pain history and has been contacted as she is the primary care physician's partner. LN completed pain assessment on resident #83, reviewed all non-pharmacological and pharmacological interventions and found them to be appropriate. Any patient who has pain concerns may be affected by this deficient practice. All residents with pain will be assessed for proper non-pharmacological and pharmacological interventions to be implemented. All residents plan of care has been reviewed and updated regarding pain, insuring proper pharmacological and	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 medications, as needed pain (PRN) medications and non-pharmacological interventions for pain management. The Care Area Assessment (CAA) dated 11/4/14, indicated the goal was for improvement, slow/minimize decline and maintain current level of functioning. The CAA identified a mood decline and physical limitations as contributing/limiting affect. The Pain Data Collection and Assessment form dated 10/31/14, identified R83 did not verbalize pain, but has noted grimacing and frowning with cares and activity, unable to determine R83's pain goal, and irritability and change in mood noted. The MDS dated 11/21/14, identified moderate cognitive impairment with no change. MDS identified R83 had worsening mild depression and constant, severe pain. The MDS identified that R83 had felt tired or had little energy almost every day. The MDS identified R83 was on scheduled pain medications, and did not identify the use of any PRN pain medications. MDS identified R83 had non-pharmacological interventions for pain management and rated R83's pain at a 10 on a scale of 1-10 (10 being worst pain). R83 was admitted to the hospital on 12/17/14. According to the record R83 had been readmitted to the facility on 12/23/14, with a diagnosis of discitis of the lumbar region. R83 was readmitted with the following pain medications ordered: -Fentanyl (narcotic pain medication to treat severe pain) patch 25 mcg transdermally every 72 hours -Tylenol Extra Strength tablet, 500 mg, 1 tablet by mouth as needed four times daily (QID) for pain -Tylenol Extra Strength tablet, 500 mg, 2 tablets by mouth at bedtime for pain	F 309	non-pharmacological interventions. All residents plan of care reviewed for proper diagnosis' for pain. Nursing and therapy staff will be educated on pain management including proper medication usage, non-pharmacological interventions and notification of a LN to complete an subjective/objective pain assessment when a patient states pain is unrelieved. Staff education will include stopping a procedure if pain is present. MDS coordinator and NM will be educated on including non-pharmacological and pharmacological interventions on residents care plans. LN will use the pain scale when administering pain medications. MD and/or NP will be updated immediately,if pain medications are ineffective. DON/Designee will complete observational audits on various shifts weekly x 3 months to assure residents who have pain are being treated with pain management and non-pharmacological interventions and MD and or NP updated on non-controlled pain, PRN. Resident #51 has been assessed by an RN and has been offered Geri sleeves prevent bruising. Any resident with fragile skin has the potential to be affected by this practice. All residents care plans have been reviewed and updated regarding pressure/non-pressure related skin conditions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 -Norco (acetaminophen and hydrocodone - narcotic to treat moderate to severe pain) on hold since 10/24/14 -Lidoderm Patch discontinued 12/23/14 R83's readmission, 5 day MDS dated 12/30/14, identified moderate cognitive impairment, moderate depression and constant, severe pain. The MDS identified R83's pain to be 10/10. The Admit/Readmit Pain Assessment dated 12/23/14, identified R83 had pain to the lumbar region and R83 indicated pain was severe. R83 indicated on assessment that he had stabbing pain, activity makes it worse, laying down makes it better, the pain awakens him and R83 voiced he wanted to die. The assessment identified that R83 would not contribute to performance of his ADLs. Physical therapy (PT) services were provided for R83 from 12/24/14 to 1/2/15, for back pain. PT's discharge summary from 1/2/15, identified that R83 was significantly limited by pain, and was barely able to complete active range of motion (AROM) in bed without excruciating pain. Occupational therapy (OT) services were ordered for 12/24/14 to 1/24/15. The OT identified a goal of after 4 weeks of OT, R83 would regain maximum level of function to discharge to least restrictive environment. The OT evaluation identified that R83 was unable to wash his face or comb his hair even with set-up and unable to perform ADLs without extensive assistance throughout treatment due to pain. OT identified in therapy notes that R83 was limited by weakness and pain. R83 was discontinued from OT on 1/2/15, and included R83's statement of he wished he could get out of here because anything that's done for him is wrong, and doesn't work for him. The care plan dated 12/8/14, included diagnoses	F 309	Staff is to received education on proper transferring of patients using a gait belt and to report any pressure, or non-pressure related skin condition to the LN. The LN will contact the NM to look at proper interventions for skin care. DON/Designee will complete observational audits on various shifts of staff transfers weekly x 3 months to assure proper transfer with gait belt is used (unless care planned for lift). DON/Designee will complete observational skin audits on various shifts weekly x 3 months to observe for non-pressure related skin conditions, to assure proper skin interventions take place. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15 of osteoarthrosis unspecified general location pelvic region and thigh, other specified rehabilitation procedure other, other malaise and fatigue and difficulty walking. ADL interventions included back brace, provide assistance with ADLs and update MD/family with changes. Pain care plan goal identified R83's pain will be relieved in 1 hour of intervention. Pain interventions included: observe for and report signs of pain and discomfort, verbal complaints, restlessness, wincing, moaning, guarding. Pain assessment per protocol and prn. Pain medication as ordered by MD, monitor use and effectiveness. Repositioning and body alignment to aid in comfort as resident allows. Staff to anticipate all pain needs, i.e.. changes in body language and facial grimacing. Care plan also identified to observe use and effectiveness of medications and update family with any changes and to assess for comfort including loneliness and time spent in bed. The facility failed to develop a plan of care for R83 to include non-pharmacological interventions. On 01/13/2015, at 8:54 a.m. R83 was calling out "ow" and groaning in pain in the dining room. R83 told licensed practical nurse (LPN)-B that he wanted to go back to his room. LPN-B continued assisting in the dining room. R83 continued to grimace, tilting his head back, and gnawing his teeth in pain in the dining room. R83 told LPN-B that he wanted to go to bed. R83 continued to call out "ow" and groan in pain in the dining room. LPN-B asked R83 if it was his normal pain or a different pain. On 01/13/2015, at 9:01 a.m. LPN-A told LPN-B that R83 had not had his medication yet, and told LPN-B to park him off to the other side of the med cart because she was busy dishing up other	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 16	F 309		

residents' pills. R83 cried out and sighed loudly to LPN-A, "Oh why does my hip hurt so bad," then cried out "ow" again. LPN-A did not acknowledge R83, and continued dishing up other residents' pills.

On 01/13/2015, at 9:08 a.m. R83 continued to call out "ow" in pain in the hallway next to the LPN, and LPN-A did not give R83 medication or address R83 in any way.

On 01/13/2015, at 9:13 a.m. LPN-A provided medication crushed in applesauce with a spoon. LPN-A told R83 he was not going to go to bed yet. LPN-A told housekeeping there was no one available to transfer R83 to bed yet and he can't go in his room. R83 was seated in the day area with other residents near the TV.

On 1/13/15, at 9:31 a.m. R83 stated his back, legs, and chest really hurt, but hips not quite as much. R83 described his pain as shooting pain that comes and goes in his back and his legs. R83 described his pain as it feels like someone is running over his head on the railroad tracks. R83 stated his wrist hurts too. R83 stated that if he lays too long he has muscle pain in his right leg, near his thigh and that it hurt at that time. R83 stated pain goes from 1-10, and when it gets to 10 it lasts for 8-10 seconds. R83 stated he makes noise when he is hurting, he hollers and staff say they will get him some medicine. R83 stated, "Sometimes I get something, and sometimes I don't." R83 was grimacing, short of breath and visibly in pain during the interview.

On 01/13/2015, at 9:53 a.m. the surveyor pushed R83's call light after he requested he wanted to lay down because his bottom was hurting. R83

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 17 stated the staff seem to think the cushion helps, but it doesn't really help keep his bottom from hurting. R83 stated he use to do therapy exercises for awhile and then they passed him up because he couldn't do the things they wanted him to. R83 stated he had PT and pretty soon they didn't even want to try anymore because it hurt too much, they 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. On 1/13/15, at 3:35 p.m. R83 was observed waking up from a nap. R83 rated his pain 6-8 in his legs with any movement. On 01/14/2015, at 7:50 a.m. NA-B was observed performing R83's morning cares. R83 stated he hurt all over. NA-B did not respond to R83's complaints of pain. R83 went on to say his feet hurt so bad and his heels burned. NA-B touched his leg to put socks on, R83 was grimacing and wincing in pain. R83 calling out "ow" and grimacing and sighing in pain while NA-B attempted to put R83's shoes on. R83 calling out, "Oh my neck, back and legs" when gripper socks were put on. R83 stated his pain was at a 10. NA-B did not respond to R83 about his pain rating of 10 and left the room. RN-A assisted NA-B to	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 18	F 309		

transfer R83 into his wheelchair. R83 was grimacing and calling out, "Oh my back." R83 was yelling, "I'm not ready, ow, I cant take this." NA-B told R83, "come on." R83 was calling out his back hurt "so damn bad." RN-A stated, "We'll get you some Tylenol or something." NA asked if R83's back feels better and R83 stated, "No, Oh God no it doesn't feel better." NA-A did not acknowledge R83's pain and told R83 he was going to brush his teeth and RN-A stated she would be back to take R83 to breakfast. R83 continued to cry out, "Oh my back" as NA-A pushed R83 up to bathroom sink and turned the water on. R83 continued to call out "ow, ow, ow", as he was grimacing and panting with teeth brushing.

On 01/14/2015, at 8:18 a.m. R83 cried out "ow", and LPN-A did not acknowledge him. LPN-A continued to dish up other residents' pills. R83 continued to say "ow" and grimace and pant. LPN-A told R83, "Hold on, I am just getting it ready here."

On 01/14/2015, at 8:21 a.m. R83 yelling out in pain, "ow", gasping. LPN-A gave R83 pills in applesauce.

On 01/14/2015, at 8:59 a.m. R83 was grimacing and saying "ow" in the dining room. LPN-A asked R83 if he wanted to go back to his room. R83 stated he did want to go to his room. LPN-A told a staff person that R83 was having pain and R83 was brought to sit in the back of dayroom.

On 01/14/2015, at 9:22 a.m. NA-C came to dayroom and told R83 he could lay down in a second.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 19 On 01/14/2015, at 9:24 a.m. NA-C and NA-A were observed assisting R83 into bed from wheelchair. R83 stated his shoulders and back really hurt. NA-C stated R83's back had been sore since he came in and the weather was a cause. R83 was holding his breath in the lift, grimacing, trying to catch his breath. R83 was calling out, "Oh my neck." R83 asked the NAs, "Why does everything have to hurt so bad." R83 continued to grimace and cry out in bed. NA-A told NA-C that R83 always does this when you lay him down. NA-A and NA-C confirmed that R83 had a lot of pain and he is the most comfortable in bed. The NAs confirmed that R83 had pain whenever he is in his wheelchair or whenever they move or transfer him. Both NAs confirmed R83 has been in pain since admission and his level depends on the time of day. Both NAs reviewed their care sheet and stated that there was nothing on their care sheets from the care plan about pain. NA-A stated the surgery did not take R83's pain away like it should have, and the pain medications were not working. NA-A stated that the only non-pharmacological intervention for R83's pain was to lay him down in bed. On 1/14/15, at 7:30 a.m. NA-B stated R83 has had pain since his operation and the surgery didn't work. NA-B stated that sometimes R83 looks like he is dying in pain. NA-B stated R83's pain limits his daily activities and R83 likes his bed the most. NA-B feels they control his pain the best they can. NA-B stated R83 always tells him he feels horrible and he wants to fall asleep and die. NA-B stated the non-pharmacological intervention for R83's pain was to try to position him once in a while and he wears a back brace. NA-B stated R83 sometimes asks him for medicine depending on his pain and mood.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 20 On 01/14/2015, at 8:28 a.m. RN-A stated R83 has daily pain in his back after back surgery and possible abscess. RN-A stated R83 is in bed more because of his back. RN-A stated R83 mostly has pain with transfers. She added an acceptable pain level for R83 is when he can perform transfers and can perform his daily activities. RN-A stated R83 complains daily of pain and doesn't always ask for pain medication, but felt R83's pan was controlled with prn medications. RN-A stated R83 had been in pain since admission and no longer receives PT, OT or nursing rehab. RN-A stated she is not sure of R83's pain level, but felt it was mild to moderate depending on what he was doing. RN-A confirmed R83's care plan and only contained the non-pharmacological intervention of letting him rest. On 01/14/2015, at 8:40 a.m. NA-J stated that R83 has chronic pain. NA-J stated R83's surgery didn't work and that nothing seems to work. NA-J stated R83 has pain 24/7 and if R83 moves he yanks his body with sharp pain. NA-J stated that R83's pain severely limits his daily living. NA-J stated she felt that R83's pain was not controlled, but they try to do what the doctor says. NA-J stated what helps R83's pain is if he lays in bed. NA-J stated she knows when the medicine is working by talking to him and they can toilet and reposition him without R83 screaming. NA-J stated that every time you move or turn R83 he will tell you he is in pain. NA-J stated that she felt R83's daily pain was between 7-8 and that he is yelling out in pain daily. NA-J stated R83 is to be repositioned every 2 hours and use his back brace for non-pharmacological interventions.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 21 On 01/14/2015, at 8:50 a.m. LPN-B stated she sees R83 in pain most days, and that he jumps in pain. On 1/14/15, at 9:45 a.m. LPN-C stated R83 does have pain. LPN-C stated she can tell if R83's pain is controlled depending on his mood, and if he is busy and not bored he won't complain. LPN-C stated an acceptable level of pain for him would be 0, comfortable, pain free. LPN-C stated his pain medication was effective if he was happy and did not want to lay down as much. LPN-C stated if R83 is bored, then he has pain. LPN-C stated R83's average pain if he lays still is 2-3, if he moves 5-8, and it depends on what's wrong. LPN-C stated, "I don't know what more we can do for him, if he has pain medications then he is more of a fall risk." On 01/14/2015, at 12:55 p.m. LPN-A stated R83 complains more when he is up and wants to lay down. LPN-A stated R83 always wants to lay down. LPN-A stated she felt R83's pain was chronic. She stated she would expect R83 to call out during transfers because his back is a sensitive area. LPN-A stated she felt an acceptable level of pain for R83 is none, no one should have pain. LPN-A stated it is hard to do anything for R83's pain, and R83 is sensitive to narcotics. LPN-A stated she felt that R83's pain is not debilitating. LPN-A stated that she felt R83 was calling out more, and he likes attention. LPN-A stated the more you pay attention to him, the more his pain is exaggerated. LPN-A stated that the facility has asked the doctor many times for different pain medications, and the doctor emailed the director of nursing (DON) and told her to quit asking for pain medications, so that is what they were doing. LPN-A stated that R83 had	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 22	F 309		

a history of alcoholism and when he came back from hospital his liver function was impaired requiring low dose pain medication.

On 01/14/2015, at 2:06 p.m. RN-A confirmed that R83 did not trigger for pain on the admission CAA. RN-A stated R83 was reassessed for pain on 12/23/14, and had complaints of continuous, stabbing, lower back pain. LPN-A stated that laying down alleviates his pain and activity makes it worse. RN-A confirmed the pain assessment dated 12/23/14, that R83 will voice he just wants to die. The assessment also indicated R83's pain prevents R83 from contributing to the performance of his ADLs, limits his activity participation and R83's mobility is decreased because of his pain. RN-A stated that she was aware that R83 was calling out in pain and that (MD name) and the nurse practitioner (GNP) were aware that R83 was calling out in pain. RN-A stated she would not expect R83 to call out in pain. RN-A stated she was not aware that R83's pain was moderate in November 2014, and in December 2014, R83's pain was 10/10 on assessment. RN-A stated she knew that doctor really does not want to make any changes to R83's pain medications until R83 completes his antibiotic on January 30th, 2015, and has a repeat MRI. RN-A stated, "I honestly am not sure of what we can do, we have tried different medications and doses, and heat packs. I cant think of anything else we can do to treat R83's pain." RN-A confirmed R83's pain medication regimen.

On 01/14/2015, at 3:11 p.m. RN-C and DON were Interviewed. RN-C stated R83 had fallen and had compression fractures to his vertebrae. RN-C stated R83 had a kyphoplasty procedure for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23	F 309		

vertebrae and did not get any better. RN-C stated a fax was sent to GNP-A to address R83's pain. RN-A stated they were told 83 was not getting anything else for pain and to stop asking. RN-C stated that R83 came back on Vicodin (narcotic medication for moderate to severe pain).The Vicodin was put on hold due to behaviors and R83 now gets Tylenol and the Fentanyl patch (narcotic medication through patch on skin). RN-A stated R83's doctor was more concerned about R83's kidneys, and less about his liver, meanwhile they keep waiting for improvement. RN-C stated R83's family did not want R83 to receive Vicodin as they did not want R83 confused and falling. RN-A stated R83 has stated to him on and off that he wants to die and this is no way to live. RN-C and DON confirmed that R83 does not have a clinical diagnosis of chemical dependency. GNP-A has explained to RN-C R83's history of alcoholism and poor renal and liver function. DON confirmed there was nothing in R83's medical record diagnosing alcoholism history and rationale for not prescribing other narcotic pain medications.

On 01/15/2015, at 8:09 a.m. the DON was interviewed and stated the facility did not get the medical director involved with R83's pain management.

On 01/15/2015, at 8:21 a.m. certified occupational therapy assistant (COTA) was interviewed. COTA stated that R83 was discharged from therapy after about a week. The COTA stated that R83's back pain was the main problem. The COTA stated that between therapy and R83's family they decided that therapy was not helping and R83 was not making progress. The COTA stated R83's pain was continuous and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 24	F 309		

limited his ability to participate. The COTA stated R83 does not get nursing rehab and was not on a walking schedule because of pain. The COTA stated R83 was unable to receive range of motion services because of pain. The COTA stated R83's pain was severe, chronic and every day. The COTA stated R83's pain was when he is moving and it is a shooting pain. R83 winces when he just sits in his chair. COTA stated R83 had stated to her that he wishes he would die because of the pain, and wished it would just go away. COTA stated R83's feelings were understandable. COTA stated that the family and doctors limit R83's pain medication because it made R83 disoriented. COTA stated when R83 was admitted he was lost and disoriented and when he was taken off pain medications he was more clear. The COTA stated she would see R83 before he got his pain medication in the morning. COTA stated sitting up in bed was really hard for R83. COTA stated when R83 was rolled on his side he would wince and going from supine to sitting and R83 would say "that kills me doing when your doing that." She stated she let the nurse know he had that much pain and asked if R83 can have pain medication because he was only on Tylenol per the doctor and family, and they decided not to. COTA stated R83 did not improve at all during therapy and R83 was discharged from therapy 1/2/15.

On 01/15/2015, at 9:20 a.m. the GNP-A was interviewed. GNP-A stated R83 was in constant pain. GNP-A stated R83 has been on so many things for pain, and stated because of their fear of him falling they took away narcotics and left the pain patch. GNP-A stated the brace was not the best thing in the world and R83 constantly keeps pulling at it. GNP-A stated R83 tells her he would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 25	F 309		

just like to have a drink when she sees him. GNP-A stated R83 was still having pain and the main floor was the best floor for him because when R83 was upstairs he dwelled on his pain. GNP-A stated she talked to his MD about R83's pain and he wanted to wait 6 weeks per the surgeon and do another MRI as R83 could have an abscess, and then surgically they would do something. GNP-A stated, "We have tried everything, at one point we took [R83] off all his pain medication except for Tylenol with no difference. [R83's] pain stayed the same no matter what we give him." GNP-A stated if R83's cognitive level declines and he falls one too many times he will not get better. GNP-A stated, "Nothing we have done has changed [R83's] level of pain. Not sure is he's a surgical candidate, kidneys bad, livers worse. Nothing we have done, nothing has changed the level of pain. R83 is either groggy or his back hurts." GNP-A stated it has been a long haul with R83 and his level of pain staying the same.

On 01/15/2015, at 3:25 p.m. family member (FM)-A was interviewed. FM-A stated he was concerned regarding the follow up from the doctor about R83's pain. FM-A stated that if the MD says R83 can do better then R83 would want that. FM-A stated, "I don't know why he is still in this much pain. I was told that after his back surgery he fell down a couple times." FM-A stated R83 has fallen 2-3 times since he got back from the hospital and did not see the doctor. FM-A stated he was concerned after R83 was having falls only a week after back surgery and was complaining of pain, and has not seen the doctor. FM-A stated he was concerned that there was no real way of telling if something happened to R83's back during the falls after surgery.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 26	F 309		

On 01/15/2015, 3:42 p.m. R83 stated he not satisfied with his pain control. R83 stated, "They keep saying they are going to do something, and they don't do anything." R83 stated he was worried about rocking the boat if he talks about his pain. R83 stated his pain was about 5/10 when he was laying down in bed, and 10/10 with shooting pain when he moves. R83 stated it seems like nothing can be done for him. " I don't want to be dead, nobody wants to be dead. There have been different times that I have I talked about and felt I wanted to die." R83 stated he wanted to die because he hurts. R83 also stated that waiting to go to the bathroom makes him sad, and says that's just the way it is.

On 01/15/2015, at 4:16 p.m. the administrator and DON were interviewed. Administrator stated they can assess, but asked what they can do when a MD is adamant about not giving something else for pain. DON stated that LSW did not document the statements about wanting to die, but told her that R83 meant he was ready to die versus him wanting to die.

On 01/16/2015, at 10:10 a.m. the medical director (MD)-A was interviewed. The medical director stated that R83's primary MD and GNP-A have kept her in the loop, but the facility has not contacted her to step in to assist with R83's pain management. MD-A stated she understands that when R83 is at rest that he is fine, but when he gets up he is wincing in pain. MD-A stated she feels they had relatively controlled his pain, but R83 was not pain free. She was not aware of R83's statements of wanting to die or that he is better off dead. MD-A stated she talked to GNP-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 27 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.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 28 No further prn medication given or documentation of non-pharmacological interventions for R83's pain. -12/26/14, at 7:21 a.m. R83 was complaining of back pain with verbal and non-verbal indicators of pain. Writer noted that R83 had scheduled pain medications. No prn medication or non-pharmacological interventions documented for R83's pain. -12/26/14, at 22:14 R83 showing signs and symptoms of back pain with facial grimacing and guarding. Writer stated that scheduled HS Tylenol has been helpful. R83 was showing signs and symptoms of pain with any activity and repositioning. No further prn medication or non-pharmacological interventions documented for R83's pain. -12/27/14, at 1458 R83 was grimacing and moaning with transfers using the mechanical lift. No prn medication or non-pharmacological interventions documented for R83's pain. -12/28/14, at 14:28 R83 was showing signs and symptoms of pain with transfers and repositioning. No prn medication or non-pharmacological interventions documented for R83's pain. -12/30/14, at 15:27 R83 requested medication for lower back pain and rated pain 7/10. Tylenol was documented as effective. -12/31/14, at 1840 R83 was showing signs and symptoms of back pain with facial grimacing and guarding. Writer said that scheduled Tylenol was helpful. -1/1/15, at 12:59 R83 yells out in pain with transfers and reported back pain this shift. No prn medication or non-pharmacological interventions documented for R83's pain. -1/1/15, at 20:22 R83 continues to have complaints of lower back pain. Writer indicates	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 29	F 309		

that both prn and the scheduled Tylenol provide only minimal relief for R83. Writer also noted that back brace only provided minimal relief. No further prn medication or non-pharmacological interventions documented for R83's pain.
-1/2/15, at 21:36 R83 has verbal and non-verbal signs and symptoms of pain throughout the shift and reports pain and weakness to legs. No prn medication documented or any documentation of non-pharmacological interventions for R83's pain.
-1/3/15, at 19:11 R83 had back pain rated 9/10, prn Tylenol given. No documentation of Tylenol effectiveness or other non-pharmacological interventions documented.
-1/4/15, at 6:38 a.m. R83 continued to have back pain. Writer indicated R83 had scheduled pain medications. No prn medication or non-pharmacological interventions documented for R83's pain.
-1/6/15, at 7:31 a.m. R83 was grimacing and has signs and symptoms of pain. Tylenol given, no documentation of effectiveness.
-1/6/15, at 8:53 a.m. Call was received from MD's nurse and writer updated her on R83's pain, nurse said that she would update MD.
-1/9/15, at 8:57 a.m. R83 was found sitting on his buttocks leaning up against his bed after trying to reach his urinal. R83 complained of back pain the entire time. No prn medication or non-pharmacological interventions documented for R83's pain or medical attention pursued.
-1/10/15, at 11:42 R83 was given prn Tylenol and was going out with family to aid in his discomfort to back. Tylenol not documented effective until 15:06.
-1/12/15, at 11:06 a.m. GNP visited R83 and noted his fall of 1/9/15. GNP made no changes to R83's medications or orders.
-1/13/15, at 9:18 p.m. R83 complained of bilateral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 30	F 309		

hip pain and was given Tylenol. Tylenol documented effective.
-1/14/15, at 8:33 a.m. R83 requested medication for back pain, Tylenol was administered and documented effective. R83 stated that as long as he is in bed there is no pain.
The Pain Management Policy revised 4/09, identified that residents are screened for pain regularly through observing the resident during daily care and/or observing for signs and symptoms of pain.

R51's care plan dated, 3/17/10, directed staff to observe skin with routine daily care, and to report to nurse any changes noted, and to observe for bruising as it is a potential side effect of aspirin therapy. The care plan also directed staff to complete weekly skin inspection with documentation of results.

The quarterly MDS dated 12/29/14, indicated R51 was cognitively intact and required assistance for all activities of daily living. The MDS indicated R51 had diagnoses which included degenerative joint disease, edema, Parkinson's, diabetes mellitus (DM) and osteoarthritis.

During observation on 1/13/15, at 3:36 p.m. R51 was seated in a wheelchair next to the bed. Observed one large dark purple bruise, approximately 3 x 3 inches on the resident's right forearm, also observed 3 smaller dark purple bruises on resident's left hand and 1 small bruise on resident's left forearm. R51 stated the bruise on the right forearm happened a couple of days ago when her arm bumped the grab bar on the bed. R51 stated the bruises on the left arm and hand also happened a couple days ago and were caused when staff assist her left arm up to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 31	F 309		

grab bar next to the toilet. R51 stated staff grab her shirt to assist her left arm up to the toilet and by accident get her skin in with her clothes. R51 reported that she does take a daily aspirin and bruises easily. R51 stated she had not told staff about the bruises, then stated she was sure staff had seen the bruises because they help her get dressed and undressed everyday.

During medical record review, no documentation was evident to indicate R51 had bruises on the right and left forearms and left hand.

Skin assessment dated 9/29/14, indicated R51 was at risk for skin breakdown related to limited mobility, DM, edema, peripheral vascular disease and bladder incontinence. The skin assessment directed licensed staff to complete weekly skin assessments.

During interview on 1/14/15, at 9:57 a.m. NA-B confirmed she assisted R51 with daily cares including dressing on 1/14/15. NA-B reported R51 has real thin skin and staff have to be very careful when moving her arms. NA-B stated she did not notice any new bruises, but did state R51 had black and blue bruises on both arms and hands. NA-B reported the nurses all know about those bruises on R51's arms and hands. When asked if NA-B had reported the bruises to the nurses, she stated, no because the resident has always had those bruises on her skin ever since she came here to this facility.

During interview on 1/14/15, at 9:59 a.m. LPN-A reported R51 bruises very easily, but could not confirm if R51 currently had any bruises without reviewing the medical record. LPN-A confirmed she was the nurse for R51 on 1/14/15. LPN-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 32 stated staff would monitor bruises by documenting bruises in the progress notes on the resident's bath days. LPN-A reviewed R51's progress notes, and LPN-A reported the last progress note documented was on 1/2/15, and indicated no concerns to body surface at that time. LPN-A stated R51's last weekly skin inspection would have been on 1/9/15 (R51's bath day) and confirmed that the weekly skin assessment documentation was missing in the record related to skin condition. LPN-A confirmed no staff had reported R51 having any bruising to hands or arms. LPN-A stated she does not work with R51 consistently, and works all three floors. During interview on 1/14/15, at 12:47 p.m. the DON stated staff are expected to observe for bruising during daily cares and report bruises to nurses right away so the nurse can assess and monitor the bruise in the progress notes until resolved. The DON confirmed staff are expected to follow the care plan which included documenting results of weekly skin inspections. Review of the facility's Pressure Ulcers/Skin Integrity/Wound Management policy dated September 13, 2011, indicated the facility had a system in place for the prevention, identification, treatment, and documentation of pressure and non-pressure wounds.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 33 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents identified at risk for pressure ulcers received the necessary care and treatment to promote healing and prevent the development of further pressure ulcers for 2 of 2 resident (R49, R102) in the sample identified at risk for pressure ulcers. Findings include: 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. 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, turn and reposition every 4 hours, and to wear	F 314	Resident #49 and #120 have been assessed by the NM of their unit and have not developed any skin impairments due to deficient practice. Resident #49 and #120 care plans have been reviewed and updated. Resident #49 and # 120 care plan and NAR group assignment sheet was reviewed for proper offloading requirements by LN, and are appropriate. All residents at FOL who require repositioning assistance may be affected by this deficient practice. All residents have TTT assessments completed quarterly and PRN, and interventions implemented as appropriate. All residents care plans have been reviewed and updated regarding repositioning. Nursing staff will receive education on skin care and pressure ulcer prevention including following care plans for toileting and repositioning.including following their group assignments which they are to carry. Group assignments reveal toileting, repositioning and assistive devices residents require. LN will receive education on following plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34 right AFO (foot drop brace) with transfers and when in wheel chair. R49's Nurse Aid Care Plan dated 1/15/15, directed staff to use derma savers to left heel while in recliner and bed and off load heels with pillow. Review of R49's Nursing Home Notes dated 11/26/14, from general nurse practioner (GNP) documented: "The staff noted that he has a deep tissue injury of his left lateral heel. He has a 2 cm length x 1 cm width purple blister area that is intact on his left lateral heel. Shoes and socks were on and these were removed. They are not to be on patient's feet. Left lateral deep tissue injury. Keep shoes off at this time. Continue to assess the left heel, off load it with gel boots, paint with betadine and I will reassess it again next week." During observation of morning cares on 1/14/15, at 7:05 a.m. nursing assistant (NA)-E and NA-F were getting R49 dressed while he was sitting in his recliner. After R49's shirt was on, NA-E proceeded to assist R49 to do a pivot transfer into his wheelchair. R49 was observed to have black tennis shoes on both feet with no AFO brace to his right foot. R49 was brought out of his room at that time. At 8:00 a.m. R49 requested to return to his room, and sat in his wheelchair until 8:48 a.m. At 8:48 a.m. R49 was sitting in his recliner in his room, and his feet were elevated up on the foot rest of the recliner and continued to wear his black tennis shoes on his feet. At 9:02 a.m. the resident continued to sit in his recliner and the GNP entered his room and proceeded to take the black tennis shoes off to look at his left heel GNP	F 314	of care for residents with any skin impairments. DON/Designees will complete observational random audits on various shifts weekly for 3 months to assure deficient practice has been corrected regarding toileting and repositioning. DON/Designee will complete observational audits on various shifts weekly regarding pressure ulcers/skin conditions for measuring of wounds, x 3 months to assure deficient practice has been corrected regarding prevention/healing of pressure sores. QAA will review results over next 3 months to review for trends and any deficient practice. completion Date: 2/25/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35 stated R49 had a black scab approximately 2 cm x 1 cm and "right foot is good." During observation on 1/15/15, at 3:30 p.m. R49 was sitting in his recliner, had his feet elevated up on the foot rest of the recliner. R49 had no shoes on, and the derma saver boots were laying on his bed and not on his feet. R49's Braden Scale For Predicting Pressure Sore Risk dated 12/16/14, indicated R49 had mild risk for developing pressure ulcers. R49's Tissue Tolerance Collection Sheet dated 11/25/14, indicated skin issues related to pressure on R49's left heel, and indicated R49 was to have his left heel off loaded with derma savers on. R49's treatment administration record (TAR) dated 1/14/15, directed staff to apply betadine to deep tissue injuries/feet topically one time a day for deep tissue injury to left heel until scab falls off, and to wear right AFO with transfers and when in wheelchair. Observe for redness and document findings. R49's Ulcer/Wound Documentation Form indicating the following measurements of R49's deep tissue injury to his left outer heel: 11/24/14-length 2.1 centimeters (cm) x 1.2 cm width-contacted wound nurse/next rounds. 12/10/14-length 2.3 cm x 1.3 cm width- fluid filled blister with no drainage 12/17/14-length 1.7 cm x 0.8 cm width 12/29/14-length 1.5 cm x 0.5 cm width 1/9/15- scabbed over area (dry skin noted) not measured	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 36 1/14/15- continue to monitor per wound nurse, not measured. Reviewed R49's Progress Notes from 11/1/14 to 1/14/14: 11/22/14- "Found dark blister type area on left out side heel, not open, air dry, no complaints of discomfort, the area is 5 cm long x 2 cm wide, applied heel guard derma protector." 11/24/14- "Left outer heel area intact purplish discoloration, occupational therapy (OT) aware and said to continue with derma save heel guards in recliner and in bed. OT looked at area and said we are also to off load heels when in bed and recliner, this was put on resident's care plan and have wound nurse look at on Wednesday." 11/28/14-"Betadine to heel, skin intact." 12/7/14-"Left outer heel remains intact, fluid filled, derma saver placed and off loaded with use of folded blanket." 12/12/14- "Left heel site dry and intact, blackened, betadine applied, off loading in bed and recliner and wearing derma saver." 12/19/14- "Blister on right heel gone left out heel blister, dry, no infection, drainage, redness." 1/5/15-"Left outer heel site unchanged." 1/12/15- "Left heel site crusted and dry, no infection, betadine treatment applied." During interview on 1/14/15, at 8:55 a.m. GNP stated R49 had deep tissue injuries caused by wearing his shoes in the recliner. GNP stated R49 liked to sit in his recliner, and staff was instructed to ensure R49 had his heels off loaded, should not be wearing shoes, and should be wearing gel boots. During interview on 1/14/15, at 1:39 p.m. R49's	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 37 family member (FM)-F stated R49 got the deep tissue injury on his heel from crossing his feet with his shoes on in the recliner. During interview on 1/14/15, at 2:00 p.m. NA-E stated R49 was to be wearing derma savers on his feet, should have his shoes off with his heels over the foot rest of recliner and off load heels. NA-E stated this is completed for R49, "When I remember to do it." During a follow up interview on 1/15/15, at 10:36 a.m. NA-E confirmed R49 was to be wearing a AFO brace to his right foot for transfers and while in his wheelchair. R49 stated R49 had not been wearing the AFO brace and she was not aware where the brace was at. During interview on 1/15/15, at 10:45 a.m. physical therapist assistant (PTA)-A stated R49 was to wear a AFO brace to his right foot and stated, "I am not sure if he has been wearing it." PTA-A stated there was an order for R49 to wear the AFO brace, so nursing staff should be putting it on. During interview on 1/15/15 at 11:20 a.m. registered nurse (RN)-B confirmed that R49's shoes should be off when he is in the recliner, should have gel boots on, and should be wearing the AFO brace. During interview on 1/15/15, at 3:15 p.m. director of nursing (DON) confirmed the current care plan for R49 instructed staff R49 was to have a AFO brace to his right foot during transfer to protect the heel and while in his wheelchair, and was to have derma safer gel boots when in the recliner.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 38	F 314		

R102's quarterly MDS dated 12/16/14, identified the resident had diagnoses including depression, healing hip fracture, right arm below the elbow amputee, congestive heart failure, fatigue, and chronic kidney disease. The MDS also identified the resident had no cognitive impairment and required extensive assistance for all areas of daily living except eating.

R102's Tissue Tolerance Collection Sheet dated 12/10/14, identified R102 was able to be seated in the wheel chair and lay in bed for 2 hours without redness to bony prominence's.

R102's current care plan dated 12/8/14, identified the resident had a risk for skin break down related to decreased mobility, and staff was instructed to turn and reposition R102 every 2 hours and as needed, and to explain risks and benefits to the resident of allowing staff to assist with changing incontinent clothing and brief, and not to remain in wet clothing.

R102 was not repositioned for greater than 4 hours on 1/14/2015.

During continuous observation of R102 on 1/14/2015, the following was observed:
7:11 a.m. R102 was seated in the hallway in a wheel chair.
7:49 a.m. R102 remained in his wheelchair in the dining room.
8:17 a.m. R102 was brought to the television room and remained in his wheelchair without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 39	F 314		

being repositioned.
8:54 a.m. R102 remained in the television area in the wheelchair and had not been repositioned.
8:57 a.m. R102 was brought to the edge of the room for an activity and remained in the wheelchair.
9:09 a.m. R102 remained in the activity in his wheel chair.
10:25 a.m. R102 remained seated in the wheelchair and had not been repositioned.
10:48 a.m. NA-D pushed R102 to the dining area by the nurses station and provided R102 a snack.
R102 had not been repositioned since 7:11 a.m.

During interview on 1/14/15, at 10:32 a.m. NA-E stated the nursing assistants did not have assignments to care for specific residents, and stated it was, "Just free for all."

During a follow up interview on 01/14/2015, at 10:42 a.m. NA-E stated staff did not provide cares on a time schedule, and she was not aware R102 was on a repositioning schedule. NA-E stated R102 was often in his wheel chair all morning. NA-E stated she was not aware if R102 had been repositioned that morning.

During interview on 1/14/2015, at 10:51 a.m. NA-D stated R102 would tell staff if he needed to stand and/ or be repositioned, and she believed R102 was not on a repositioning schedule.

During interview on 1/14/2015, at 11:06 a.m. NA-F stated R102 did not have a scheduled repositioning plan, but staff would usually take him to the bathroom in the morning around 10:00-10:30 a.m., and stated she had not assisted R102 with toileting or repositioning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 40 During interview on 1/14/2015, 11:13 a.m. RN-B stated R102's current care plan indicated R102 required extensive assistance with repositioning, and instructed staff to reposition the resident every two hours. During observation on 1/14/2015, at 11:22 a.m. RN-B and NA-F were asked to assist R102 with toileting. NA-B and NA-F assisted R102 to stand and transfer to the toilet. R102's skin on his buttocks was intact, but wrinkled and creased. During interview on 1/16/2015, at 10:11 a.m. RN-B stated R102 was assessed to be repositioned every 2 hrs, however, the nursing assistant care sheet (identified as what the NAs used to provide cares to residents) did not instruct staff to turn and reposition every two hours to prevent skin breakdown. During interview on 1/16/2015, at 11:31 a.m. the DON stated R102 should have been toileted and/or repositioned every 2 hours, and stated the resident should not have gone over 4 hours without toileting/repositioning. The facility policy titled Pressure Ulcers/Skin Integrity/Wound Management-HDGR dated 9/13/2011, identified Treatment/ Management; Residents with risk for or who have a loss of skin integrity will receive the appropriate treatment/services, and residents who are determined to be at risk for, or who have loss of skin integrity, will receive the appropriate treatment/services which may include reposition or "off-loading" as per resident assessment and care plan.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 41	F 315		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based observation, interview, and document review, the facility failed to ensure that 1 of 1 residents (R102) in the sample requiring assistance received timely assistance with toileting. Findings include: R102's diagnoses included healing hip fracture, right arm below the elbow amputee, and chronic kidney disease. R102's quarterly Minimum Data Set (MDS) dated 12/16/14, identified R102 was cognitively intact. However, during an interview on 1/13/2015, at 9:55 a.m. R102 identified he was not sure if he had eaten this morning and he had already been observed to eat breakfast. R102 was also unaware that he lived in a nursing home. The quarterly MDS also identified R102 required extensive assistance for toileting. R102's current care plan dated to be revised 12/8/14, identified he required toileting every two hours and as needed. R102 was to be checked and changed if already incontinent.	F 315	Resident #102 had B&B completed, care plan has been reviewed and updated, resident has been assessed per the RN and has had no negative outcomes related the deficient practice. All residents needing assistance with toileting maybe affected by this deficit practice. All residents care plans have been reviewed and updated regarding toileting and repositioning. All residents are assessed for individual B&B plans, and appropriate interventions. Nursing staff have been educated on following resident's plan of care, individual toileting and repositioning plans. LN will update care plans and NAR group assignment's PRN related to individual toileting and repositioning schedules. DON/Designee will complete observational audits weekly on various shifts x 3 months to assure NAR's are	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 42 During intermittent observations on 1/14/2015, from 7:11 a.m. and 9:09 a.m. and continuous observation from 9:13 a.m. through 10:48 a.m. R102 had not been assisted with toileting. During observation on 1/14/15, at 11:22 a.m. R102 was assisted to toilet. R102 had been incontinent of stool, with a small amount of soft non formed stool on his bottom and in the incontinence brief. 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, "We just free for all it." During a second interview on 1/14/15, at 10:42 a.m. NA-E identified staff do not provide cares on a time schedule. NA-E further identified R102 would tell staff if he needed to go to the bathroom. NA-E verified it was not unusual for R102 to be in his wheelchair all morning. NA-E verified that she had not assisted R102 to the toilet so far that morning. During an interview on 1/14/15, at 10:51 a.m. NA-D indicated R102 would tell staff if he needed to go to the bathroom. NA-D identified she believed R102 was not on a toileting plan. NA-D verified that she had not toileted R102 so far that morning. During interview on 1/14/15, at 11:06 a.m. NA-F indicated R102 did not have a scheduled toileting plan. NA-F identified R102 was continent of bowel and bladder, and at times knew if he needed to go to the bathroom or if he had been incontinent. NA-F indicated R102 would usually be taken to the bathroom in the morning. NA-F verified she had not toileted R102.	F 315	carrying their group sheets and are following interventions listed on the care sheet. DON/Designee will complete observational audits on documentation weekly on various shifts x 3 months, to assure NAR's are following care plan related to toileting and repositioning. 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 compledted by: 2/25/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 43 During an interview on 1/14/15, at 11:10 a.m. licensed practical nurse (LPN)-B verified the nursing assistants provide care for the residents according to the nursing assistant sheets. LPN-B identified she believed R102 was continent of bowel and bladder and he would ask for assistance with toileting. During an interview on 1/16/2015, at 10:11 a.m. registered nurse (RN)-B verified R102 was assessed to be toileted every 2 hrs and it was on the care plan. However, it was not on the nursing assistant care sheet, "and that is why it was missed." RN-B verified the nursing assistant care sheets had been revised to reflect the need for toileting every two hours. During an interview on 1/16/15, at 11:31 a.m. the director of nursing (DON) verified she would expect residents care to be performed as directed by the resident assessments and care plan.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING **01 - DINING ADDITION 01** B. WING _____	**02/06/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Fair Oaks Lodge 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

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

Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING **01 - DINING ADDITION 01** B. WING _____	**02/06/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was surveyed as 2 buildings. Fair Oaks Lodge was constructed at four different times. In 1995 the kitchen and dining building 02 was constructed to the west of the 1965 building and is a 2-story addition that was determined to be of Type IV(2HH) construction. It is separated with a 10 foot enclosed walkway and a 2-hour fire barrier. No sleeping rooms are in this building. The original building (02 Main Building) was constructed in 1965, was determined to be of Type II (222) construction and has a wood roof system that meets the exception to NFPA 101 Sec 19.1.6.2. In 1972 a 3-story addition was constructed to the east of the original building that is 3-story building, no basement and was determined to be of Type II (222) construction and has a wood roof system that meets the exception to NFPA 101 Sec 19.1.6.2. In 1976, a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING **01 - DINING ADDITION 01** B. WING _____	**02/06/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 2-story addition was constructed to the south that was determined to be of Type II(222) construction. The facility is completely sprinkler protected with a dry pipe system and a wet pipe system (in the 1995 addition). The facility has smoke detection in the corridor system, in all areas open to the corridor, in all common areas and in all sleeping rooms that are on the facility's fire alarm system that has automatic fire department notification. The facility has a capacity of 75 beds and had a census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm	K 052	Director of Maintenance/Designee will have smoke detectors installed to be	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING **01 - DINING ADDITION 01** B. WING _____	**02/06/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 3 system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting residents, staff, and visitors of the facility. Findings include: On facility tour between 8:00 AM on 11:00 AM on 02/06/2015, observations revealed that the smoke detectors located in the ramp corridor leading to the kitchen and by the east exit of the lower level were installed within 36 inches of HVAC diffusers. This deficient practice was verified by the Director of Maintenance.	K 052	more than 36 inches from HVAC diffusers. Corrective Action is to be completed by : 2/25/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**02/06/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 02 Kitchen and Dining Addition A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Fair Oaks Lodge 02 Kitchen/Dining Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was surveyed as 2 buildings. Fair Oaks Lodge was constructed at four different times. In 1995 the kitchen and dining building 02 was constructed to the west of the 1965 building and is a 2-story addition that was determined to be of Type IV(2HH) construction. It is separated with a 10 foot enclosed walkway and a 2-hour fire barrier. No sleeping rooms are in this building. The original building (02 Main Building) was constructed in 1965, was determined to be of Type II (222) construction and has a wood roof system that meets the exception to NFPA 101 Sec 19.1.6.2. In 1972 a 3-story addition was constructed to the east of the original building that is 3-story building, no basement and was determined to be of Type II (222) construction and has a wood roof system that meets the exception to NFPA 101 Sec 19.1.6.2. In 1976, a 2-story addition was constructed to the south that was determined to be of Type II(222)	K 000	EPOC	

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

Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**02/06/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 construction. The facility is completely sprinkler protected with a dry pipe system and a wet pipe system (in the 1995 addition). The facility has smoke detection in the corridor system, in all areas open to the corridor, in all common areas and in all sleeping rooms that are on the facility's fire alarm system that has automatic fire department notification. The facility has a capacity of 75 beds and had a census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) are MET.	K 000		

MINNESOTA MDH DEPARTMENT OF HEALTH

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 only a suggestion 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 1/12/15 through 1/16/15, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	The facility has 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Certification Program; 1505 Pebble Lake Rd, Suite 300, Fergus Falls, MN 56537.	2 000	orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic	2 302		2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 2 topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided information for care of residents with Alzheimer's disease and dementia in a written or electronic form. In addition, the facility failed to identify a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training. The facility's current admission packet was reviewed, which included facility services provided and multiple documents given to a new resident upon admission. The admission packet did not include information regarding the Alzheimer's disease training program. During interview on 1/16/15, at 12:54 p.m. the administrator confirmed the facility had not informed their consumers of the Alzheimer's training information in written or electronic form. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could add information regarding the Alzheimer's disease and dementia requirements into the resident admission packet for consumer information. The quality assurance committee could design a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Nursing staff will be trained annually on dementia, including disease process and behaviors of residents, and how to assist with ADL's and communication techniques. SW/Designee will hold Family Council meetings at least bi-annually, and inform residents families by placing a letter in the admission packets.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 3	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan that included the daily use of Remeron (an antidepressant medication) and a PRN (as needed) order for Ativan (an antianxiety medication) for 1 of 5 residents (R31) reviewed for unnecessary medications. Findings include: R31 was admitted to the facility 3/25/14. Diagnosis identified on the Order Summary Report included anxiety, adult failure to thrive and other personality disorder. The Order Summary Report also identified that R31 received Remeron 7.5 mg (milligrams), at bedtime to increase appetite, decrease anxiety and help to sleep, as well as Ativan 0.5 mg three times per day PRN for anxiety or sleep. The Minimum Data Set (MDS) dated 12/12/14, did not identify a BIMS score (brief interview for mental status) for cognition. The PPS	2 560	SW/MDS Coordinator and Nurse Managers will receive education on completing care plans that include incorporating these classes of medications in their care plans. SW/NM will update all care plans to assure the class of medication is included in current care plans and MDS/SW will develop care plans for all new admissions. DON/Designee will assure process is completed and will audit care plans weekly x 3 months to assure system is intact. 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	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 4 (prospective payment system) MDS dated August 28, 2014, identified a BIMS of 8 indicating moderately impaired cognition. Review of the medication administration records (MAR) for October, November and December 2014, and January 2015, indicated that R31 took Ativan twice in October, nine times in November, four times in December and 5 times in January (through 1/14/15). Review of the behavior charting in the nurses notes identified anxious behaviors occurred almost daily. The facility care plan created on 6/27/14, identified mood/behaviors of verbally abusive behaviors related to ineffective coping skills and poor impulse control. Non pharmacological interventions of monitor and anticipate resident's needs, monitor every shift and document observed behavior and attempted interventions in behavior log, monitor resident's understanding of the situation and allow time for the resident to express himself, provide positive feedback for good behavior and emphasize the positive aspects of compliance, when he becomes agitated intervene before agitation escalates, guide away form source of distress, engage calmly in conversation. The use of the Remeron and Ativan were not addressed on the care plan. During interview with the director of nursing on 1/14/15, at 2:30 p.m. she verified that the medications were not addressed on the care plan and that she would expect them to be. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 5 interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the written plan of care for 2 of 2 residents (R49, R102) reviewed at risk for pressure ulcers, for 1 of 2 resident (R102) who required assistance with toileting, and for 1 of 3 residents (R51) reviewed for non-pressure related skin conditions. Findings include: 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	2 565	Nursing staff will receive education on skin care and pressure ulcer prevention including following care guides for turning schedules and on following residents plan of care, including following their group assignments which they are to carry. Group assignments reveal toileting, repositioning and assistive devices residents require. LN will receive education on following plan of care for residents with bruising. DON/Designee will complete random audits weekly for 3 months to assure deficient practice has been corrected. QAA will review results over next 3 months to review for trends and any deficient practice.	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 6 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. 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, turn and reposition every 4 hours, and to wear right AFO (foot drop brace) with transfers and when in wheel chair. R49's Nurse Aid Care Plan dated 1/15/15, directed staff to use derma savers to left heel while in recliner and bed and off load heels with pillow. During observation of morning cares on 1/14/15, at 7:05 a.m. nursing assistant (NA)-E and NA-F were getting R49 dressed while he was sitting in his recliner. After R49's shirt was on, NA-E proceeded to assist R49 to do a pivot transfer into his wheelchair. R49 was observed to have black tennis shoes on both feet with no AFO brace to his right foot. R49 was brought out of his room at that time. At 8:48 a.m. R49 was sitting in his recliner in his room, and his feet were elevated up on the foot rest of the recliner and continued to wear his black tennis shoes on his feet. At 9:02 a.m. the resident continued to sit in his recliner and the GNP entered his room and proceeded to take the black tennis shoes off to look at his left heel GNP stated R49 had a black scab approximately 2 cm x 1 cm and "right foot is good." During observation on 1/15/15, at 3:30 p.m. R49	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 7 was sitting in his recliner, had his feet elevated up on the foot rest of the recliner. R49 had no shoes on, and the derma saver boots were laying on his bed and not on his feet. R49's Tissue Tolerance Collection Sheet dated 11/25/14, indicated skin issues related to pressure on R49's left heel, and indicated R49 was to have his left heel off loaded with derma savers on. During interview on 1/14/15, at 8:55 a.m. GNP stated R49 had deep tissue injuries caused by wearing his shoes in the recliner. GNP stated R49 liked to sit in his recliner, and staff was instructed to ensure R49 had his heels off loaded, should not be wearing shoes, and should be wearing gel boots. During interview on 1/14/15, at 2:00 p.m. NA-E stated R49 was to be wearing derma savers on his feet, should have his shoes off with his heels over the foot rest of recliner and off load heels. NA-E stated this is completed for R49, "When I remember to do it." During a follow up interview on 1/15/15, at 10:36 a.m. NA-E confirmed R49 was to be wearing a AFO brace to his right foot for transfers and while in his wheelchair. R49 stated R49 had not been wearing the AFO brace and she was not aware where the brace was at. During interview on 1/15/15, at 10:45 a.m. physical therapist assistant (PTA)-A stated R49 was to wear a AFO brace to his right foot and stated, "I am not sure if he has been wearing it." PTA-A stated there was an order for R49 to wear the AFO brace, so nursing staff should be putting it on.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 8 During interview on 1/15/15 at 11:20 a.m. registered nurse (RN)-B confirmed that R49's shoes should be off when he is in the recliner, should have gel boots on, and should be wearing the AFO brace. During interview on 1/15/15, at 3:15 p.m. director of nursing (DON) confirmed the current care plan for R49 instructed staff R49 was to have a AFO brace to his right foot during transfer to protect the heel and while in his wheelchair, and was to have derma safer gel boots when in the recliner. R102 was not assisted with repositioning according to the plan of care. R102's quarterly MDS dated 12/16/14, identified the resident had diagnoses including depression, healing hip fracture, right arm below the elbow amputee, congestive heart failure, fatigue, and chronic kidney disease. The MDS also identified the resident had no cognitive impairment and required extensive assistance for all areas of daily living except eating. R102's Tissue Tolerance Collection Sheet dated 12/10/14, identified R102 was able to be seated in the wheelchair and lay in bed for 2 hours without redness to bony prominence's. R102's current care plan dated 12/8/14, identified the resident had a risk for skin break down related to decreased mobility, and staff was instructed to turn and reposition R102 every 2 hours and as needed, and to explain risks and benefits to the resident of allowing staff to assist with changing incontinent clothing and brief, and not to remain in wet clothing. During continuous observation of R102 on	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 9 1/14/2015, the following was observed: 7:11 a.m. R102 was seated in the hallway in a wheel chair. 7:49 a.m. R102 remained in his wheelchair in the dining room. 8:17 a.m. R102 was brought to the television room and remained in his wheelchair without being repositioned. 8:54 a.m. R102 remained in the television area in the wheelchair and had not been repositioned. 8:57 a.m. R102 was brought to the edge of the room for an activity and remained in the wheelchair. 9:09 a.m. R102 remained in the activity in his wheel chair. 10:25 a.m. R102 remained seated in the wheelchair and had not been repositioned. 10:48 a.m. NA-D pushed R102 to the dining area by the nurses station and provided R102 a snack. R102 had not been repositioned since 7:11 a.m. During interview on 1/14/15, at 10:32 a.m. NA-E stated the nursing assistants did not have assignments to care for specific residents, and stated it was, "Just free for all." During a follow up interview on 01/14/2015, at 10:42 a.m. NA-E stated staff did not provide cares on a time schedule, and she was not aware R102 was on a repositioning schedule. NA-E stated R102 was often in his wheel chair all morning. NA-E stated she was not aware if R102 had been repositioned that morning. During interview on 1/14/2015, 11:13 a.m. RN-B stated R102's current care plan indicated R102 required extensive assistance with repositioning, and instructed staff to reposition the resident every two hours.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 10 During observation on 1/14/2015, at 11:22 a.m. RN-B and NA-F were asked to assist R102 with toileting. NA-B and NA-F assisted R102 to stand and transfer to the toilet. R102's skin on his buttocks was intact, but wrinkled and creased. During interview on 1/16/2015, at 10:11 a.m. RN-B stated R102 was assessed to be repositioned every 2 hrs, however, the nursing assistant care sheet (identified as what the NAs used to provide cares to residents) did not instruct staff to turn and reposition every two hours to prevent skin breakdown. During interview on 1/16/2015, at 11:31 a.m. the DON stated R102 should have been repositioned every 2 hours, and stated the resident should not have gone over 4 hours without repositioning. R102 was not provided timely assistance with toileting according to the plan of care. R102's diagnoses included healing hip fracture, right arm below the elbow amputee, and chronic kidney disease. R102's quarterly MDS dated 12/16/14, identified R102 was cognitively intact. The quarterly MDS also identified R102 required extensive assistance for toileting. R102's current care plan dated to be revised 12/8/14, identified he required toileting every two hours and as needed. R102 was to be checked and changed if already incontinent. During intermittent observations on 1/14/2015, from 7:11 a.m. and 9:09 a.m. and continuous observation from 9:13 a.m. through 10:48 a.m. R102 had not been assisted with toileting. During observation on 1/14/15, at 11:22 a.m. R102 was assisted to toilet. R102 had been incontinent of stool, with a small amount of soft non formed stool on his bottom and in the incontinence brief.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 11 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." During a second interview on 1/14/15, at 10:42 a.m. NA-E identified staff do not provide cares on a time schedule. NA-E further identified R102 would tell staff if he needed to go to the bathroom. NA-E verified it was not unusual for R102 to be in his wheelchair all morning. NA-E verified that she had not assisted R102 to the toilet so far that morning. During an interview on 1/14/15, at 10:51 a.m. NA-D indicated R102 would tell staff if he needed to go to the bathroom. NA-D identified she believed R102 was not on a toileting plan. NA-D verified that she had not toileted R102 so far that morning. During interview on 1/14/15, at 11:06 a.m. NA-F indicated R102 did not have a scheduled toileting plan. NA-F identified R102 was continent of bowel and bladder, and at times knew if he needed to go to the bathroom or if he had been incontinent. NA-F indicated R102 would usually be taken to the bathroom in the morning. NA-F verified she had not toileted R102. During an interview on 1/16/2015, at 10:11 a.m. RN-B verified R102 was assessed to be toileted every 2 hrs and it was on the care plan. However, it was not on the nursing assistant care sheet, "and that is why it was missed." RN-B verified the nursing assistant care sheets had been revised to reflect the need for toileting every two hours. During an interview on 1/16/15, at 11:31 a.m. the	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 12 DON verified she would expect residents care to be performed as directed by the resident assessments and care plan. R51's skin condition was not assessed, monitored or documented according to the care plan. The care plan dated, 3/17/10, directed staff to observe skin with routine daily care, and to report to nurse any changes noted, and to observe for bruising as it is a potential side effect of aspirin therapy. The care plan also directed staff to complete weekly skin inspection with documentation of results. The quarterly MDS dated 12/29/14, indicated R51 was cognitively intact and required assistance for all activities of daily living. The MDS indicated R51 had diagnoses which included degenerative joint disease, edema, Parkinson's, diabetes mellitus (DM) and osteoarthritis. During observation on 1/13/15, at 3:36 p.m. R51 was seated in a wheelchair next to the bed. Observed one large dark purple bruise, approximately 3 x 3 inches on the resident's right forearm, also observed 3 smaller dark purple bruises on resident's left hand and 1 small bruise on resident's left forearm. R51 stated the bruise on the right forearm happened a couple of days ago when her arm bumped the grab bar on the bed. R51 stated the bruises on the left arm and hand also happened a couple days ago and were caused when staff assist her left arm up to the grab bar next to the toilet. R51 stated staff grab her shirt to assist her left arm up to the toilet and by accident get her skin in with her clothes. R51 reported that she does take a daily aspirin and	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 13	2 565		

bruises easily. R51 stated she had not told staff about the bruises, then stated she was sure staff had seen the bruises because they help her get dressed and undressed everyday.

During medical record review, no documentation was evident to indicate R51 had bruises on the right and left forearms and left hand.

Skin assessment dated 9/29/14, indicated R51 was at risk for skin breakdown related to limited mobility, DM, edema, peripheral vascular disease and bladder incontinence. The skin assessment directed licensed staff to complete weekly skin assessments.

During interview on 1/14/15, at 9:57 a.m. NA-B confirmed she assisted R51 with daily cares including dressing on 1/14/15. NA-B reported R51 has real thin skin and staff have to be very careful when moving her arms. NA-B stated she did not notice any new bruises, but did state R51 had black and blue bruises on both arms and hands. NA-B reported the nurses all know about those bruises on R51's arms and hands. When asked if NA-B had reported the bruises to the nurses, she stated, no because the resident has always had those bruises on her skin ever since she came here to this facility.

During interview on 1/14/15, at 9:59 a.m. LPN-A reported R51 bruises very easily, but could not confirm if R51 currently had any bruises without reviewing the medical record. LPN-A confirmed she was the nurse for R51 on 1/14/15. LPN-A stated staff would monitor bruises by documenting bruises in the progress notes on the resident's bath days. LPN-A reviewed R51's progress notes, and LPN-A reported the last progress note documented was on 1/2/15, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 14 indicated no concerns to body surface at that time. LPN-A stated R51's last weekly skin inspection would have been on 1/9/15 (R51's bath day) and confirmed that the weekly skin assessment documentation was missing in the record related to skin condition. LPN-A confirmed no staff had reported R51 having any bruising to hands or arms. LPN-A stated she does not work with R51 consistently, and works all three floors. During interview on 1/14/15, at 12:47 p.m. the DON stated staff are expected to observe for bruising during daily cares and report bruises to nurses right away so the nurse can assess and monitor the bruise in the progress notes until resolved. The DON confirmed staff are expected to follow the care plan which included documenting results of weekly skin inspections. Review of the facility's Care Plans-Comprehensive policy dated April 1, 2008, indicated the care plans are designed to meet the resident's medical, nursing, mental and psychosocial needs, as identified in the comprehensive assessments. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive care according to the plan of care; educate all relevant staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess pain and implement interventions to relieve moderate to severe pain following a surgical procedure to the lower back for 1 of 1 resident (R83) reviewed for pain, and failed to monitor skin condition for 1 of 1 resident (R51) reviewed with multiple bruises to skin. This deficient practice caused actual harm to R83. Findings include; R83's admission Minimum Data Set (MDS) dated 10/31/14, identified R83 had diagnoses which included arthritis, other specific rehabilitation procedure, malaise and fatigue, and difficulty walking. The MDS identified R83 had severe cognitive impairment and required extensive assistance for activities of daily living (ADLs). Further, the MDS identified R83 had occasional,	2 830	Nursing staff have been educated on following resident's plan of care, including following their group assignments which they are to carry with them. Group assignments reveal toileting, repositioning and assistive devices residents require. LN have received education on following plan of care for residents with bruising. DON/Designee will audit weekly x 3 months to assure NAR's are carrying their group sheets and are following interventions listed on the care sheet. DON/Designee will monitor documentations weekly to assure nurse's are following care plan on any resident with care plan related to bruising. Findings from audits will be reviewed at QAA x 3 months to assure trends or negative findings of audits are corrected.	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16 moderate pain, received scheduled pain medications, as needed pain (PRN) medications and non-pharmacological interventions for pain management. The Care Area Assessment (CAA) dated 11/4/14, indicated the goal was for improvement, slow/minimize decline and maintain current level of functioning. The CAA identified a mood decline and physical limitations as contributing/limiting affect. The Pain Data Collection and Assessment form dated 10/31/14, identified R83 did not verbalize pain, but has noted grimacing and frowning with cares and activity, unable to determine R83's pain goal, and irritability and change in mood noted. The MDS dated 11/21/14, identified moderate cognitive impairment with no change. MDS identified R83 had worsening mild depression and constant, severe pain. The MDS identified that R83 had felt tired or had little energy almost every day. The MDS identified R83 was on scheduled pain medications, and did not identify the use of any PRN pain medications. MDS identified R83 had non-pharmacological interventions for pain management and rated R83's pain at a 10 on a scale of 1-10 (10 being worst pain). R83 was admitted to the hospital on 12/17/14. According to the record R83 had been readmitted to the facility on 12/23/14, with a diagnosis of discitis of the lumbar region. R83 was readmitted with the following pain medications ordered: -Fentanyl (narcotic pain medication to treat severe pain) patch 25 mcg transdermally every 72 hours -Tylenol Extra Strength tablet, 500 mg, 1 tablet by mouth as needed four times daily (QID) for pain -Tylenol Extra Strength tablet, 500 mg, 2 tablets by mouth at bedtime for pain	2 830	Corrected Action is to be completed by 2.25/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 -Norco (acetaminophen and hydrocodone - narcotic to treat moderate to severe pain) on hold since 10/24/14 -Lidoderm Patch discontinued 12/23/14 R83's readmission, 5 day MDS dated 12/30/14, identified moderate cognitive impairment, moderate depression and constant, severe pain. The MDS identified R83's pain to be 10/10. The Admit/Readmit Pain Assessment dated 12/23/14, identified R83 had pain to the lumbar region and R83 indicated pain was severe. R83 indicated on assessment that he had stabbing pain, activity makes it worse, laying down makes it better, the pain awakens him and R83 voiced he wanted to die. The assessment identified that R83 would not contribute to performance of his ADLs. Physical therapy (PT) services were provided for R83 from 12/24/14 to 1/2/15, for back pain. PT's discharge summary from 1/2/15, identified that R83 was significantly limited by pain, and was barely able to complete active range of motion (AROM) in bed without excruciating pain. Occupational therapy (OT) services were ordered for 12/24/14 to 1/24/15. The OT identified a goal of after 4 weeks of OT, R83 would regain maximum level of function to discharge to least restrictive environment. The OT evaluation identified that R83 was unable to wash his face or comb his hair even with set-up and unable to perform ADLs without extensive assistance throughout treatment due to pain. OT identified in therapy notes that R83 was limited by weakness and pain. R83 was discontinued from OT on 1/2/15, and included R83's statement of he wished he could get out of here because anything that's done for him is wrong, and doesn't work for him. The care plan dated 12/8/14, included diagnoses of osteoarthrosis unspecified general location	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 18 pelvic region and thigh, other specified rehabilitation procedure other, other malaise and fatigue and difficulty walking. ADL interventions included back brace, provide assistance with ADLs and update MD/family with changes. Pain care plan goal identified R83's pain will be relieved in 1 hour of intervention. Pain interventions included: observe for and report signs of pain and discomfort, verbal complaints, restlessness, wincing, moaning, guarding. Pain assessment per protocol and prn. Pain medication as ordered by MD, monitor use and effectiveness. Repositioning and body alignment to aid in comfort as resident allows. Staff to anticipate all pain needs, i.e.. changes in body language and facial grimacing. Care plan also identified to observe use and effectiveness of medications and update family with any changes and to assess for comfort including loneliness and time spent in bed. The facility failed to develop a plan of care for R83 to include non-pharmacological interventions. On 01/13/2015, at 8:54 a.m. R83 was calling out "ow" and groaning in pain in the dining room. R83 told licensed practical nurse (LPN)-B that he wanted to go back to his room. LPN-B continued assisting in the dining room. R83 continued to grimace, tilting his head back, and gnawing his teeth in pain in the dining room. R83 told LPN-B that he wanted to go to bed. R83 continued to call out "ow" and groan in pain in the dining room. LPN-B asked R83 if it was his normal pain or a different pain. On 01/13/2015, at 9:01 a.m. LPN-A told LPN-B that R83 had not had his medication yet, and told LPN-B to park him off to the other side of the med cart because she was busy dishing up other residents' pills. R83 cried out and sighed loudly to LPN-A, "Oh why does my hip hurt so bad," then	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 cried out "ow" again. LPN-A did not acknowledge R83, and continued dishing up other residents' pills. On 01/13/2015, at 9:08 a.m. R83 continued to call out "ow" in pain in the hallway next to the LPN, and LPN-A did not give R83 medication or address R83 in any way. On 01/13/2015, at 9:13 a.m. LPN-A provided medication crushed in applesauce with a spoon. LPN-A told R83 he was not going to go to bed yet. LPN-A told housekeeping there was no one available to transfer R83 to bed yet and he can't go in his room. R83 was seated in the day area with other residents near the TV. On 1/13/15, at 9:31 a.m. R83 stated his back, legs, and chest really hurt, but hips not quite as much. R83 described his pain as shooting pain that comes and goes in his back and his legs. R83 described his pain as it feels like someone is running over his head on the railroad tracks. R83 stated his wrist hurts too. R83 stated that if he lays too long he has muscle pain in his right leg, near his thigh and that it hurt at that time. R83 stated pain goes from 1-10, and when it gets to 10 it lasts for 8-10 seconds. R83 stated he makes noise when he is hurting, he hollers and staff say they will get him some medicine. R83 stated, "Sometimes I get something, and sometimes I don't." R83 was grimacing, short of breath and visibly in pain during the interview. On 01/13/2015, at 9:53 a.m. the surveyor pushed R83's call light after he requested he wanted to lay down because his bottom was hurting. R83 stated the staff seem to think the cushion helps, but it doesn't really help keep his bottom from hurting. R83 stated he use to do therapy	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 20	2 830		

exercises for awhile and then they passed him up because he couldn't do the things they wanted him to. R83 stated he had PT and pretty soon they didn't even want to try anymore because it hurt too much, they 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.

On 1/13/15, at 3:35 p.m. R83 was observed waking up from a nap. R83 rated his pain 6-8 in his legs with any movement.

On 01/14/2015, at 7:50 a.m. NA-B was observed performing R83's morning cares. R83 stated he hurt all over. NA-B did not respond to R83's complaints of pain. R83 went on to say his feet hurt so bad and his heels burned. NA-B touched his leg to put socks on, R83 was grimacing and wincing in pain. R83 calling out "ow" and grimacing and sighing in pain while NA-B attempted to put R83's shoes on. R83 calling out, "Oh my neck, back and legs" when gripper socks were put on. R83 stated his pain was at a 10. NA-B did not respond to R83 about his pain rating of 10 and left the room. RN-A assisted NA-B to transfer R83 into his wheelchair. R83 was grimacing and calling out, "Oh my back." R83 was yelling, "I'm not ready, ow, I cant take this." NA-B told R83, "come on." R83 was calling out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 21 his back hurt "so damn bad." RN-A stated, "We'll get you some Tylenol or something." NA asked if R83's back feels better and R83 stated, "No, Oh God no it doesn't feel better." NA-A did not acknowledge R83's pain and told R83 he was going to brush his teeth and RN-A stated she would be back to take R83 to breakfast. R83 continued to cry out, "Oh my back" as NA-A pushed R83 up to bathroom sink and turned the water on. R83 continued to call out "ow, ow, ow", as he was grimacing and panting with teeth brushing. On 01/14/2015, at 8:18 a.m. R83 cried out "ow", and LPN-A did not acknowledge him. LPN-A continued to dish up other residents' pills. R83 continued to say "ow" and grimace and pant. LPN-A told R83, "Hold on, I am just getting it ready here." On 01/14/2015, at 8:21 a.m. R83 yelling out in pain, "ow", gasping. LPN-A gave R83 pills in applesauce. On 01/14/2015, at 8:59 a.m. R83 was grimacing and saying "ow" in the dining room. LPN-A asked R83 if he wanted to go back to his room. R83 stated he did want to go to his room. LPN-A told a staff person that R83 was having pain and R83 was brought to sit in the back of dayroom. On 01/14/2015, at 9:22 a.m. NA-C came to dayroom and told R83 he could lay down in a second. On 01/14/2015, at 9:24 a.m. NA-C and NA-A were observed assisting R83 into bed from wheelchair. R83 stated his shoulders and back really hurt. NA-C stated R83's back had been sore since he came in and the weather was a	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 22	2 830		

cause. R83 was holding his breath in the lift, grimacing, trying to catch his breath. R83 was calling out, "Oh my neck." R83 asked the NAs, "Why does everything have to hurt so bad." R83 continued to grimace and cry out in bed. NA-A told NA-C that R83 always does this when you lay him down. NA-A and NA-C confirmed that R83 had a lot of pain and he is the most comfortable in bed. The NAs confirmed that R83 had pain whenever he is in his wheelchair or whenever they move or transfer him. Both NAs confirmed R83 has been in pain since admission and his level depends on the time of day. Both NAs reviewed their care sheet and stated that there was nothing on their care sheets from the care plan about pain. NA-A stated the surgery did not take R83's pain away like it should have, and the pain medications were not working. NA-A stated that the only non-pharmacological intervention for R83's pain was to lay him down in bed.

On 1/14/15, at 7:30 a.m. NA-B stated R83 has had pain since his operation and the surgery didn't work. NA-B stated that sometimes R83 looks like he is dying in pain. NA-B stated R83's pain limits his daily activities and R83 likes his bed the most. NA-B feels they control his pain the best they can. NA-B stated R83 always tells him he feels horrible and he wants to fall asleep and die. NA-B stated the non-pharmacological intervention for R83's pain was to try to position him once in a while and he wears a back brace. NA-B stated R83 sometimes asks him for medicine depending on his pain and mood.

On 01/14/2015, at 8:28 a.m. RN-A stated R83 has daily pain in his back after back surgery and possible abscess. RN-A stated R83 is in bed more because of his back. RN-A stated R83 mostly has pain with transfers. She added an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 23 acceptable pain level for R83 is when he can perform transfers and can perform his daily activities. RN-A stated R83 complains daily of pain and doesn't always ask for pain medication, but felt R83's pan was controlled with prn medications. RN-A stated R83 had been in pain since admission and no longer receives PT, OT or nursing rehab. RN-A stated she is not sure of R83's pain level, but felt it was mild to moderate depending on what he was doing. RN-A confirmed R83's care plan and only contained the non-pharmacological intervention of letting him rest. On 01/14/2015, at 8:40 a.m. NA-J stated that R83 has chronic pain. NA-J stated R83's surgery didn't work and that nothing seems to work. NA-J stated R83 has pain 24/7 and if R83 moves he yanks his body with sharp pain. NA-J stated that R83's pain severely limits his daily living. NA-J stated she felt that R83's pain was not controlled, but they try to do what the doctor says. NA-J stated what helps R83's pain is if he lays in bed. NA-J stated she knows when the medicine is working by talking to him and they can toilet and reposition him without R83 screaming. NA-J stated that every time you move or turn R83 he will tell you he is in pain. NA-J stated that she felt R83's daily pain was between 7-8 and that he is yelling out in pain daily. NA-J stated R83 is to be repositioned every 2 hours and use his back brace for non-pharmacological interventions. On 01/14/2015, at 8:50 a.m. LPN-B stated she sees R83 in pain most days, and that he jumps in pain. On 1/14/15, at 9:45 a.m. LPN-C stated R83 does have pain. LPN-C stated she can tell if R83's pain is controlled depending on his mood, and if he is	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 24	2 830		

busy and not bored he won't complain. LPN-C stated an acceptable level of pain for him would be 0, comfortable, pain free. LPN-C stated his pain medication was effective if he was happy and did not want to lay down as much. LPN-C stated if R83 is bored, then he has pain. LPN-C stated R83's average pain if he lays still is 2-3, if he moves 5-8, and it depends on what's wrong. LPN-C stated, "I don't know what more we can do for him, if he has pain medications then he is more of a fall risk."

On 01/14/2015, at 12:55 p.m. LPN-A stated R83 complains more when he is up and wants to lay down. LPN-A stated R83 always wants to lay down. LPN-A stated she felt R83's pain was chronic. She stated she would expect R83 to call out during transfers because his back is a sensitive area. LPN-A stated she felt an acceptable level of pain for R83 is none, no one should have pain. LPN-A stated it is hard to do anything for R83's pain, and R83 is sensitive to narcotics. LPN-A stated she felt that R83's pain is not debilitating. LPN-A stated that she felt R83 was calling out more, and he likes attention. LPN-A stated the more you pay attention to him, the more his pain is exaggerated. LPN-A stated that the facility has asked the doctor many times for different pain medications, and the doctor emailed the director of nursing (DON) and told her to quit asking for pain medications, so that is what they were doing. LPN-A stated that R83 had a history of alcoholism and when he came back from hospital his liver function was impaired requiring low dose pain medication.

On 01/14/2015, at 2:06 p.m. RN-A confirmed that R83 did not trigger for pain on the admission CAA. RN-A stated R83 was reassessed for pain on 12/23/14, and had complaints of continuous,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 25 stabbing, lower back pain. LPN-A stated that laying down alleviates his pain and activity makes it worse. RN-A confirmed the pain assessment dated 12/23/14, that R83 will voice he just wants to die. The assessment also indicated R83's pain prevents R83 from contributing to the performance of his ADLs, limits his activity participation and R83's mobility is decreased because of his pain. RN-A stated that she was aware that R83 was calling out in pain and that (MD name) and the nurse practitioner (GNP) were aware that R83 was calling out in pain. RN-A stated she would not expect R83 to call out in pain. RN-A stated she was not aware that R83's pain was moderate in November 2014, and in December 2014, R83's pain was 10/10 on assessment. RN-A stated she knew that doctor really does not want to make any changes to R83's pain medications until R83 completes his antibiotic on January 30th, 2015, and has a repeat MRI. RN-A stated, "I honestly am not sure of what we can do, we have tried different medications and doses, and heat packs. I cant think of anything else we can do to treat R83's pain." RN-A confirmed R83's pain medication regimen. On 01/14/2015, at 3:11 p.m. RN-C and DON were Interviewed. RN-C stated R83 had fallen and had compression fractures to his vertebrae. RN-C stated R83 had a kyphoplasty procedure for vertebrae and did not get any better. RN-C stated a fax was sent to GNP-A to address R83's pain. RN-A stated they were told 83 was not getting anything else for pain and to stop asking. RN-C stated that R83 came back on Vicodin (narcotic medication for moderate to severe pain).The Vicodin was put on hold due to behaviors and R83 now gets Tylenol and the Fentanyl patch (narcotic medication through patch on skin).	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 26 RN-A stated R83's doctor was more concerned about R83's kidneys, and less about his liver, meanwhile they keep waiting for improvement. RN-C stated R83's family did not want R83 to receive Vicodin as they did not want R83 confused and falling. RN-A stated R83 has stated to him on and off that he wants to die and this is no way to live. RN-C and DON confirmed that R83 does not have a clinical diagnosis of chemical dependency. GNP-A has explained to RN-C R83's history of alcoholism and poor renal and liver function. DON confirmed there was nothing in R83's medical record diagnosing alcoholism history and rationale for not prescribing other narcotic pain medications. On 01/15/2015, at 8:09 a.m. the DON was interviewed and stated the facility did not get the medical director involved with R83's pain management. On 01/15/2015, at 8:21 a.m. certified occupational therapy assistant (COTA) was interviewed. COTA stated that R83 was discharged from therapy after about a week. The COTA stated that R83's back pain was the main problem. The COTA stated that between therapy and R83's family they decided that therapy was not helping and R83 was not making progress. The COTA stated R83's pain was continuous and limited his ability to participate. The COTA stated R83 does not get nursing rehab and was not on a walking schedule because of pain. The COTA stated R83 was unable to receive range of motion services because of pain. The COTA stated R83's pain was severe, chronic and every day. The COTA stated R83's pain was when he is moving and it is a shooting pain. R83 winces when he just sits in his chair. COTA stated R83 had stated to her that he wishes he would die because of the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 27	2 830		

pain, and wished it would just go away. COTA stated R83's feelings were understandable. COTA stated that the family and doctors limit R83's pain medication because it made R83 disoriented. COTA stated when R83 was admitted he was lost and disoriented and when he was taken off pain medications he was more clear. The COTA stated she would see R83 before he got his pain medication in the morning. COTA stated sitting up in bed was really hard for R83. COTA stated when R83 was rolled on his side he would wince and going from supine to sitting and R83 would say "that kills me doing when your doing that." She stated she let the nurse know he had that much pain and asked if R83 can have pain medication because he was only on Tylenol per the doctor and family, and they decided not to. COTA stated R83 did not improve at all during therapy and R83 was discharged from therapy 1/2/15.

On 01/15/2015, at 9:20 a.m. the GNP-A was interviewed. GNP-A stated R83 was in constant pain. GNP-A stated R83 has been on so many things for pain, and stated because of their fear of him falling they took away narcotics and left the pain patch. GNP-A stated the brace was not the best thing in the world and R83 constantly keeps pulling at it. GNP-A stated R83 tells her he would just like to have a drink when she sees him. GNP-A stated R83 was still having pain and the main floor was the best floor for him because when R83 was upstairs he dwelled on his pain. GNP-A stated she talked to his MD about R83's pain and he wanted to wait 6 weeks per the surgeon and do another MRI as R83 could have an abscess, and then surgically they would do something. GNP-A stated, "We have tried everything, at one point we took [R83] off all his pain medication except for Tylenol with no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 28	2 830		

difference. [R83's] pain stayed the same no matter what we give him." GNP-A stated if R83's cognitive level declines and he falls one too many times he will not get better. GNP-A stated, "Nothing we have done has changed [R83's] level of pain. Not sure is he's a surgical candidate, kidneys bad, livers worse. Nothing we have done, nothing has changed the level of pain. R83 is either groggy or his back hurts." GNP-A stated it has been a long haul with R83 and his level of pain staying the same.

On 01/15/2015, at 3:25 p.m. family member (FM)-A was interviewed. FM-A stated he was concerned regarding the follow up from the doctor about R83's pain. FM-A stated that if the MD says R83 can do better then R83 would want that. FM-A stated, "I don't know why he is still in this much pain. I was told that after his back surgery he fell down a couple times." FM-A stated R83 has fallen 2-3 times since he got back from the hospital and did not see the doctor. FM-A stated he was concerned after R83 was having falls only a week after back surgery and was complaining of pain, and has not seen the doctor. FM-A stated he was concerned that there was no real way of telling if something happened to R83's back during the falls after surgery.

On 01/15/2015, 3:42 p.m. R83 stated he not satisfied with his pain control. R83 stated, "They keep saying they are going to do something, and they don't do anything." R83 stated he was worried about rocking the boat if he talks about his pain. R83 stated his pain was about 5/10 when he was laying down in bed, and 10/10 with shooting pain when he moves. R83 stated it seems like nothing can be done for him. " I don't want to be dead, nobody wants to be dead. There have been different times that I have I talked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 29 about and felt I wanted to die." R83 stated he wanted to die because he hurts. R83 also stated that waiting to go to the bathroom makes him sad, and says that's just the way it is. On 01/15/2015, at 4:16 p.m. the administrator and DON were interviewed. Administrator stated they can assess, but asked what they can do when a MD is adamant about not giving something else for pain. DON stated that LSW did not document the statements about wanting to die, but told her that R83 meant he was ready to die versus him wanting to die. On 01/16/2015, at 10:10 a.m. the medical director (MD)-A was interviewed. The medical director stated that R83's primary MD and GNP-A have kept her in the loop, but the facility has not contacted her to step in to assist with R83's pain management. MD-A stated she understands that when R83 is at rest that he is fine, but when he gets up he is wincing in pain. MD-A stated she feels they had relatively controlled his pain, but R83 was not pain free. She was not aware of R83's statements of wanting to die or that he is better off dead. MD-A stated she talked to GNP-A 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.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 30 -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. No further prn medication given or documentation of non-pharmacological interventions for R83's pain. -12/26/14, at 7:21 a.m. R83 was complaining of back pain with verbal and non-verbal indicators of pain. Writer noted that R83 had scheduled pain medications. No prn medication or non-pharmacological interventions documented for R83's pain. -12/26/14, at 22:14 R83 showing signs and symptoms of back pain with facial grimacing and guarding. Writer stated that scheduled HS Tylenol has been helpful. R83 was showing signs and symptoms of pain with any activity and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 31	2 830		

repositioning. No further prn medication or non-pharmacological interventions documented for R83's pain.
-12/27/14, at 1458 R83 was grimacing and moaning with transfers using the mechanical lift. No prn medication or non-pharmacological interventions documented for R83's pain.
-12/28/14, at 14:28 R83 was showing signs and symptoms of pain with transfers and repositioning. No prn medication or non-pharmacological interventions documented for R83's pain.
-12/30/14, at 15:27 R83 requested medication for lower back pain and rated pain 7/10. Tylenol was documented as effective.
-12/31/14, at 1840 R83 was showing signs and symptoms of back pain with facial grimacing and guarding. Writer said that scheduled Tylenol was helpful.
-1/1/15, at 12:59 R83 yells out in pain with transfers and reported back pain this shift. No prn medication or non-pharmacological interventions documented for R83's pain.
-1/1/15, at 20:22 R83 continues to have complaints of lower back pain. Writer indicates that both prn and the scheduled Tylenol provide only minimal relief for R83. Writer also noted that back brace only provided minimal relief. No further prn medication or non-pharmacological interventions documented for R83's pain.
-1/2/15, at 21:36 R83 has verbal and non-verbal signs and symptoms of pain throughout the shift and reports pain and weakness to legs. No prn medication documented or any documentation of non-pharmacological interventions for R83's pain.
-1/3/15, at 19:11 R83 had back pain rated 9/10, prn Tylenol given. No documentation of Tylenol effectiveness or other non-pharmacological interventions documented.
-1/4/15, at 6:38 a.m. R83 continued to have back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 32	2 830		

pain. Writer indicated R83 had scheduled pain medications. No prn medication or non-pharmacological interventions documented for R83's pain.
-1/6/15, at 7:31 a.m. R83 was grimacing and has signs and symptoms of pain. Tylenol given, no documentation of effectiveness.
-1/6/15, at 8:53 a.m. Call was received from MD's nurse and writer updated her on R83's pain, nurse said that she would update MD.
-1/9/15, at 8:57 a.m. R83 was found sitting on his buttocks leaning up against his bed after trying to reach his urinal. R83 complained of back pain the entire time. No prn medication or non-pharmacological interventions documented for R83's pain or medical attention pursued.
-1/10/15, at 11:42 R83 was given prn Tylenol and was going out with family to aid in his discomfort to back. Tylenol not documented effective until 15:06.
-1/12/15, at 11:06 a.m. GNP visited R83 and noted his fall of 1/9/15. GNP made no changes to R83's medications or orders.
-1/13/15, at 9:18 p.m. R83 complained of bilateral hip pain and was given Tylenol. Tylenol documented effective.
-1/14/15, at 8:33 a.m. R83 requested medication for back pain, Tylenol was administered and documented effective. R83 stated that as long as he is in bed there is no pain.
The Pain Management Policy revised 4/09, identified that residents are screened for pain regularly through observing the resident during daily care and/or observing for signs and symptoms of pain.

R51's care plan dated, 3/17/10, directed staff to observe skin with routine daily care, and to report to nurse any changes noted, and to observe for bruising as it is a potential side effect of aspirin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 33	2 830		

therapy. The care plan also directed staff to complete weekly skin inspection with documentation of results.

The quarterly MDS dated 12/29/14, indicated R51 was cognitively intact and required assistance for all activities of daily living. The MDS indicated R51 had diagnoses which included degenerative joint disease, edema, Parkinson's, diabetes mellitus (DM) and osteoarthritis.

During observation on 1/13/15, at 3:36 p.m. R51 was seated in a wheelchair next to the bed. Observed one large dark purple bruise, approximately 3 x 3 inches on the resident's right forearm, also observed 3 smaller dark purple bruises on resident's left hand and 1 small bruise on resident's left forearm. R51 stated the bruise on the right forearm happened a couple of days ago when her arm bumped the grab bar on the bed. R51 stated the bruises on the left arm and hand also happened a couple days ago and were caused when staff assist her left arm up to the grab bar next to the toilet. R51 stated staff grab her shirt to assist her left arm up to the toilet and by accident get her skin in with her clothes. R51 reported that she does take a daily aspirin and bruises easily. R51 stated she had not told staff about the bruises, then stated she was sure staff had seen the bruises because they help her get dressed and undressed everyday.

During medical record review, no documentation was evident to indicate R51 had bruises on the right and left forearms and left hand.

Skin assessment dated 9/29/14, indicated R51 was at risk for skin breakdown related to limited mobility, DM, edema, peripheral vascular disease and bladder incontinence. The skin assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 34 directed licensed staff to complete weekly skin assessments. During interview on 1/14/15, at 9:57 a.m. NA-B confirmed she assisted R51 with daily cares including dressing on 1/14/15. NA-B reported R51 has real thin skin and staff have to be very careful when moving her arms. NA-B stated she did not notice any new bruises, but did state R51 had black and blue bruises on both arms and hands. NA-B reported the nurses all know about those bruises on R51's arms and hands. When asked if NA-B had reported the bruises to the nurses, she stated, no because the resident has always had those bruises on her skin ever since she came here to this facility. During interview on 1/14/15, at 9:59 a.m. LPN-A reported R51 bruises very easily, but could not confirm if R51 currently had any bruises without reviewing the medical record. LPN-A confirmed she was the nurse for R51 on 1/14/15. LPN-A stated staff would monitor bruises by documenting bruises in the progress notes on the resident's bath days. LPN-A reviewed R51's progress notes, and LPN-A reported the last progress note documented was on 1/2/15, and indicated no concerns to body surface at that time. LPN-A stated R51's last weekly skin inspection would have been on 1/9/15 (R51's bath day) and confirmed that the weekly skin assessment documentation was missing in the record related to skin condition. LPN-A confirmed no staff had reported R51 having any bruising to handsor arms. LPN-A stated she does not work with R51 consistently, and works all three floors. During interview on 1/14/15, at 12:47 p.m. the DON stated staff are expected to observe for bruising during daily cares and report bruises to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 35 nurses right away so the nurse can assess and monitor the bruise in the progress notes until resolved. The DON confirmed staff are expected to follow the care plan which included documenting results of weekly skin inspections. Review of the facility's Pressure Ulcers/Skin Integrity/Wound Management policy dated September 13, 2011, indicated the facility had a system in place for the prevention, identification, treatment, and documentation of pressure and non-pressure wounds. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could train all staff and perform audits to ensure each resident is receiving appropriate nursing care and monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least	2 840		2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 36 every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based observation, interview, and document review, the facility failed to ensure that 1 of 1 residents (R102) in the sample requiring assistance received timely assistance with toileting.	2 840	Nursing staff have been educated on following resident's plan of care, including following their group assignments which they are to carry with them. Group assignments reveal bathing, toileting, repositioning and assistive devices	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 37 Findings include: R102's diagnoses included healing hip fracture, right arm below the elbow amputee, and chronic kidney disease. R102's quarterly Minimum Data Set (MDS) dated 12/16/14, identified R102 was cognitively intact. However, during an interview on 1/13/2015, at 9:55 a.m. R102 identified he was not sure if he had eaten this morning and he had already been observed to eat breakfast. R102 was also unaware that he lived in a nursing home. The quarterly MDS also identified R102 required extensive assistance for toileting. R102's current care plan dated to be revised 12/8/14, identified he required toileting every two hours and as needed. R102 was to be checked and changed if already incontinent. During intermittent observations on 1/14/2015, from 7:11 a.m. and 9:09 a.m. and continuous observation from 9:13 a.m. through 10:48 a.m. R102 had not been assisted with toileting. During observation on 1/14/15, at 11:22 a.m. R102 was assisted to toilet. R102 had been incontinent of stool, with a small amount of soft non formed stool on his bottom and in the incontinence brief. 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, "We just free for all it." During a second interview on 1/14/15, at 10:42 a.m. NA-E identified staff do not provide cares on a time schedule. NA-E further identified R102 would tell staff if he needed to go to the bathroom. NA-E verified it was not unusual for R102 to be in his wheelchair all morning. NA-E verified that she had not assisted R102 to the toilet so far that morning. During an interview on 1/14/15, at 10:51 a.m.	2 840	residents require. LN are to update NAR's group assignments PRN. DON/Designee will audit weekly x 3 months to assure NAR's are carrying their group sheets and are following interventions listed on the care sheet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 38 NA-D indicated R102 would tell staff if he needed to go to the bathroom. NA-D identified she believed R102 was not on a toileting plan. NA-D verified that she had not toileted R102 so far that morning. During interview on 1/14/15, at 11:06 a.m. NA-F indicated R102 did not have a scheduled toileting plan. NA-F identified R102 was continent of bowel and bladder, and at times knew if he needed to go to the bathroom or if he had been incontinent. NA-F indicated R102 would usually be taken to the bathroom in the morning. NA-F verified she had not toileted R102. During an interview on 1/14/15, at 11:10 a.m. licensed practical nurse (LPN)-B verified the nursing assistants provide care for the residents according to the nursing assistant sheets. LPN-B identified she believed R102 was continent of bowel and bladder and he would ask for assistance with toileting. During an interview on 1/16/2015, at 10:11 a.m. registered nurse (RN)-B verified R102 was assessed to be toileted every 2 hrs and it was on the care plan. However, it was not on the nursing assistant care sheet, "and that is why it was missed." RN-B verified the nursing assistant care sheets had been revised to reflect the need for toileting every two hours. During an interview on 1/16/15, at 11:31 a.m. the director of nursing (DON) verified she would expect residents care to be performed as directed by the resident assessments and care plan. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures	2 840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 39 to ensure that residents who require assistance with toileting receive timely services; educate staff as appropriate; then develop monitoring systems or audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 840		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents identified at risk for pressure ulcers received the necessary care and treatment to promote healing and prevent the development of further pressure ulcers for 2 of 2 resident (R49, R102) in the	2 900	Nursing staff will receive education on skin care and pressure ulcer prevention including following care guides for turning schedules and on following residents plan of care, including following their group assignments which they are to carry.	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 40 sample identified at risk for pressure ulcers. Findings include: 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. 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, turn and reposition every 4 hours, and to wear right AFO (foot drop brace) with transfers and when in wheel chair. R49's Nurse Aid Care Plan dated 1/15/15, directed staff to use derma savers to left heel while in recliner and bed and off load heels with pillow. Review of R49's Nursing Home Notes dated 11/26/14, from general nurse practioner (GNP) documented: "The staff noted that he has a deep tissue injury of his left lateral heel. He has a 2 cm length x 1 cm width purple blister area that is intact on his left lateral heel. Shoes and socks were on and these were removed. They are not to be on patient's feet. Left lateral deep tissue	2 900	Group assignments reveal toileting, repositioning and assistive devices residents require. LN will receive education on following plan of care for residents with pressure ulcers. DON/Designee will complete random audits weekly for 3 months to assure deficient practice has been corrected. QAA will review results over the next 3 months to review for trends and any deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 41 injury. Keep shoes off at this time. Continue to assess the left heel, off load it with gel boots, paint with betadine and I will reassess it again next week." During observation of morning cares on 1/14/15, at 7:05 a.m. nursing assistant (NA)-E and NA-F were getting R49 dressed while he was sitting in his recliner. After R49's shirt was on, NA-E proceeded to assist R49 to do a pivot transfer into his wheelchair. R49 was observed to have black tennis shoes on both feet with no AFO brace to his right foot. R49 was brought out of his room at that time. At 8:00 a.m. R49 requested to return to his room, and sat in his wheelchair until 8:48 a.m. At 8:48 a.m. R49 was sitting in his recliner in his room, and his feet were elevated up on the foot rest of the recliner and continued to wear his black tennis shoes on his feet. At 9:02 a.m. the resident continued to sit in his recliner and the GNP entered his room and proceeded to take the black tennis shoes off to look at his left heel GNP stated R49 had a black scab approximately 2 cm x 1 cm and "right foot is good." During observation on 1/15/15, at 3:30 p.m. R49 was sitting in his recliner, had his feet elevated up on the foot rest of the recliner. R49 had no shoes on, and the derma saver boots were laying on his bed and not on his feet. R49's Braden Scale For Predicting Pressure Sore Risk dated 12/16/14, indicated R49 had mild risk for developing pressure ulcers. R49's Tissue Tolerance Collection Sheet dated 11/25/14, indicated skin issues related to pressure on R49's left heel, and indicated R49 was to have his left heel off loaded with derma	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 42 savers on. R49's treatment administration record (TAR) dated 1/14/15, directed staff to apply betadine to deep tissue injuries/feet topically one time a day for deep tissue injury to left heel until scab falls off, and to wear right AFO with transfers and when in wheelchair. Observe for redness and document findings. R49's Ulcer/Wound Documentation Form indicating the following measurements of R49's deep tissue injury to his left outer heel: 11/24/14-length 2.1 centimeters (cm) x 1.2 cm width-contacted wound nurse/next rounds. 12/10/14-length 2.3 cm x 1.3 cm width- fluid filled blister with no drainage 12/17/14-length 1.7 cm x 0.8 cm width 12/29/14-length 1.5 cm x 0.5 cm width 1/9/15- scabbed over area (dry skin noted) not measured 1/14/15- continue to monitor per wound nurse, not measured. Reviewed R49's Progress Notes from 11/1/14 to 1/14/14: 11/22/14- "Found dark blister type area on left out side heel, not open, air dry, no complaints of discomfort, the area is 5 cm long x 2 cm wide, applied heel guard derma protector." 11/24/14- "Left outer heel area intact purplish discoloration, occupational therapy (OT) aware and said to continue with derma save heel guards in recliner and in bed. OT looked at area and said we are also to off load heels when in bed and recliner, this was put on resident's care plan and have wound nurse look at on Wednesday." 11/28/14-"Betadine to heel, skin intact."	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 43 12/7/14-"Left outer heel remains intact, fluid filled, derma saver placed and off loaded with use of folded blanket." 12/12/14- "Left heel site dry and intact, blackened, betadine applied, off loading in bed and recliner and wearing derma saver." 12/19/14- "Blister on right heel gone left out heel blister, dry, no infection, drainage, redness." 1/5/15-"Left outer heel site unchanged." 1/12/15- "Left heel site crusted and dry, no infection, betadine treatment applied." During interview on 1/14/15, at 8:55 a.m. GNP stated R49 had deep tissue injuries caused by wearing his shoes in the recliner. GNP stated R49 liked to sit in his recliner, and staff was instructed to ensure R49 had his heels off loaded, should not be wearing shoes, and should be wearing gel boots. During interview on 1/14/15, at 1:39 p.m. R49's family member (FM)-F stated R49 got the deep tissue injury on his heel from crossing his feet with his shoes on in the recliner. During interview on 1/14/15, at 2:00 p.m. NA-E stated R49 was to be wearing derma savers on his feet, should have his shoes off with his heels over the foot rest of recliner and off load heels. NA-E stated this is completed for R49, "When I remember to do it." During a follow up interview on 1/15/15, at 10:36 a.m. NA-E confirmed R49 was to be wearing a AFO brace to his right foot for transfers and while in his wheelchair. R49 stated R49 had not been wearing the AFO brace and she was not aware where the brace was at. During interview on 1/15/15, at 10:45 a.m.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 44 physical therapist assistant (PTA)-A stated R49 was to wear a AFO brace to his right foot and stated, "I am not sure if he has been wearing it." PTA-A stated there was an order for R49 to wear the AFO brace, so nursing staff should be putting it on. During interview on 1/15/15 at 11:20 a.m. registered nurse (RN)-B confirmed that R49's shoes should be off when he is in the recliner, should have gel boots on, and should be wearing the AFO brace. During interview on 1/15/15, at 3:15 p.m. director of nursing (DON) confirmed the current care plan for R49 instructed staff R49 was to have a AFO brace to his right foot during transfer to protect the heel and while in his wheelchair, and was to have derma safer gel boots when in the recliner. R102's quarterly MDS dated 12/16/14, identified the resident had diagnoses including depression, healing hip fracture, right arm below the elbow amputee, congestive heart failure, fatigue, and chronic kidney disease. The MDS also identified the resident had no cognitive impairment and required extensive assistance for all areas of daily living except eating. R102's Tissue Tolerance Collection Sheet dated 12/10/14, identified R102 was able to be seated in the wheel chair and lay in bed for 2 hours without redness to bony prominence's. R102's current care plan dated 12/8/14, identified the resident had a risk for skin break down related to decreased mobility, and staff was instructed to turn and reposition R102 every 2 hours and as needed, and to explain risks and benefits to the resident of allowing staff to assist	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 45 with changing incontinent clothing and brief, and not to remain in wet clothing. R102 was not repositioned for greater than 4 hours on 1/14/2015. During continuous observation of R102 on 1/14/2015, the following was observed: 7:11 a.m. R102 was seated in the hallway in a wheel chair. 7:49 a.m. R102 remained in his wheelchair in the dining room. 8:17 a.m. R102 was brought to the television room and remained in his wheelchair without being repositioned. 8:54 a.m. R102 remained in the television area in the wheelchair and had not been repositioned. 8:57 a.m. R102 was brought to the edge of the room for an activity and remained in the wheelchair. 9:09 a.m. R102 remained in the activity in his wheel chair. 10:25 a.m. R102 remained seated in the wheelchair and had not been repositioned. 10:48 a.m. NA-D pushed R102 to the dining area by the nurses station and provided R102 a snack. R102 had not been repositioned since 7:11 a.m. During interview on 1/14/15, at 10:32 a.m. NA-E stated the nursing assistants did not have assignments to care for specific residents, and stated it was, "Just free for all." During a follow up interview on 01/14/2015, at 10:42 a.m. NA-E stated staff did not provide cares on a time schedule, and she was not aware R102 was on a repositioning schedule. NA-E stated R102 was often in his wheel chair all morning. NA-E stated she was not aware if R102 had been repositioned that morning.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 46 During interview on 1/14/2015, at 10:51 a.m. NA-D stated R102 would tell staff if he needed to stand and/ or be repositioned, and she believed R102 was not on a repositioning schedule. During interview on 1/14/2015, at 11:06 a.m. NA-F stated R102 did not have a scheduled repositioning plan, but staff would usually take him to the bathroom in the morning around 10:00-10:30 a.m., and stated she had not assisted R102 with toileting or repositioning. During interview on 1/14/2015, 11:13 a.m. RN-B stated R102's current care plan indicated R102 required extensive assistance with repositioning, and instructed staff to reposition the resident every two hours. During observation on 1/14/2015, at 11:22 a.m. RN-B and NA-F were asked to assist R102 with toileting. NA-B and NA-F assisted R102 to stand and transfer to the toilet. R102's skin on his buttocks was intact, but wrinkled and creased. During interview on 1/16/2015, at 10:11 a.m. RN-B stated R102 was assessed to be repositioned every 2 hrs, however, the nursing assistant care sheet (identified as what the NAs used to provide cares to residents) did not instruct staff to turn and reposition every two hours to prevent skin breakdown. During interview on 1/16/2015, at 11:31 a.m. the DON stated R102 should have been toileted and/or repositioned every 2 hours, and stated the resident should not have gone over 4 hours without toileting/repositioning.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 47 The facility policy titled Pressure Ulcers/Skin Integrity/Wound Management-HDGR dated 9/13/2011, identified Treatment/ Management; Residents with risk for or who have a loss of skin integrity will receive the appropriate treatment/services, and residents who are determined to be at risk for, or who have loss of skin integrity, will receive the appropriate treatment/services which may include reposition or "off-loading" as per resident assessment and care plan. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents with or at risk for pressure ulcers receive timely services; educate staff as appropriate; then develop monitoring systems or audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 900		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from	21915		2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21915	Continued From page 48 council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview, the facility failed to attempt to organize a family council at least on an annual basis. Findings include: During an interview on 1/13/15, at 4:07 p.m., social services (SS)-A was interviewed regarding family council. SS-A indicated that she had not yet attempted to organize a family council, and had no knowledge of a family council having been attempted prior. SS-A stated she had plans to begin that process in April 2015. SS-A verified she had not informed any residents or families of these future plans. During an interview on 1/15/15, at 11:23 a.m. a family member (FM)-A stated he had not received any information regarding a family council group; however, would be interested in becoming a family council member when one was organized. During an interview on 1/16/201, at 11:41 a.m. the director of nursing (DON) verified a family council should have been attempted at least one time in the past year. SUGGESTED METHOD OF CORRECTION: The Administrator and Social Worker could develop policies to include an attempt to organize family council on at least a yearly basis. The Quality Assurance Committee could develop a system to monitor the attempts made at forming a family	21915	SW/Designee will hold Family Council meetings at least bi-annually, and inform residents families by placing a letter in the admission packets. QAA will receive minutes from SW regarding Family Council meetings to discuss and resolve any concerns at least bi-annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	01/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21915	Continued From page 49 council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915		