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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZHND

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 **12/18/2015** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 01/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/05/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/22/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5581

On December 18, 2015, the Department of Health, Licensing and Certification Program completed a Post Certification Revisit (PCR) by review of the plan of correction and on December 16, 2015 a PCR was completd by the Departments Office of Health Facility Complaints. In addition, on December 11, 2015 a PCR was completed by the Minnesota Department of Public Safety to verify that the fac ility had achieved and maintained compliance with deficiencies issued pursuant to a standard survey, (where an investigation of complaint number H5581012 was conducted and found unsubstantiated) and an abbreviated standard survey (related to complaint number H5581013, and was found substantiated at F354 and F441) completed on October 29, 2015. Based on the PCRs, we have determined the deficiencies isssues pursuant to the standard survey and the abbreviated standard surveys completed on October 29, 2015 were corrected, effective December 16, 2015. Refer to the CMS 2567b forms for the results of the revisits.

Effective December 16, 2015, the facility is certified for 75 skilled nursing facility beds.

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245581

January 5, 2016

Mr. Steve Fritzke, Administrator
Fair Oaks Lodge
201 Shady Lane Drive
Wadena, MN 56482

Dear Mr. Fritzke:

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 December 16, 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 bed.

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

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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

Electronically delivered
January 5, 2016

Mr. Steve Fritzke, Administrator
Fair Oaks Lodge
201 Shady Lane Drive
Wadena, MN 56482

RE: Project Number S5581025, H5581012, H5581013

Dear Mr. Fritzke:

On November 18, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey and an abbreviated standard survey, completed on October 29, 2015. This surveys found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 18, 2015, the Minnesota Department of Health, Licensing and Certification Program, completed a Post Certification Revisit (PCR) by review of your plan of correction and On December 16, 2105, the Department's Office of Health Facility Complaints completed a PCR. In addition, on December 11, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard and an abbreviated standard surveys, completed on October 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 8, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard and abbreviated standard surveys, completed on October 29, 2015, effective December 16, 2015 and therefore remedies outlined in our letter to you dated November 18, 2015, will not be imposed.

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
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245581	A. Building B. Wing	12/18/2015

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/08/2015**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/08/2015**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **12/08/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/08/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	01/05/2016	28034	12/18/2015
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
10/29/2015			

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**	12/11/2015

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 Reg. # **NFPA 101** LSC K0017	Correction Completed **11/24/2015**	ID Prefix Reg. # **NFPA 101** LSC K0022	Correction Completed **11/22/2015**	ID Prefix Reg. # **NFPA 101** LSC K0075	Correction Completed **12/08/2015**
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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	01/05/2016	36536	12/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/27/2015

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: ZHND

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 **10/29/2015** (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 Remarks

17. SURVEYOR SIGNATURE — Date :
Denise Erickson, HFE NEII — 12/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/21/2015 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5581

On October 29, 2015 a standard survey was completed at this facility. The most serious deficiencies were cited at a scope and severity of F. The facility has been given an opportunity to correct before remedies would be imposed. In addition, at the time of the standard survey completed on October 29, 2015, investigation of complaint H5581012 was completed. The complaint was determined to be unsubstantiated.

Minnesota Department of Health

Electronically delivered

November 18, 2015

Ms. Lyn Sebenaler, Administrator
Fair Oaks Lodge
201 Shady Lane Drive
Wadena, Minnesota 56482

RE: Project Number S5581025, H5581012

Dear Ms. Sebenaler:

On October 29, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, and on October 30, 2015, an abbreviated standard survey was completed at your facility by the Department's Office of Health Facility Complaints 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. In addition, at the time of the October 29, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5581012.

This surveys found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 29, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5581012 that was found to be unsubstantiated.

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 (**CMS 2567 form with the survey exit date of October 29, 2015**) should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140 Fax: (218) 332-5196

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 (**CMS 2567 form and State Form with the exit date of October 30, 2015**) should be directed to:

Sarah Grebenc, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
Email: sarah.grebenc@state.mn.us
Phone: (651) 201-4135 Fax: (651) 281-9796

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 December 8, 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 December 8, 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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, Office of Health Facility Complaints 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 January 29, 2016 (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 April 29, 2016 (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.

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
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
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Health Regulation Division
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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 _____	10/29/2015

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. 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. At the time of the standard survey completed on October 29, 2105, investigation of complaint H5581012 was completed. The complaint was determined to be unsubstantiated.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164		12/8/15

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

Electronically Signed | 11/24/2015

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F 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility staff failed to ensure 2 of 2 residents (R42 & R46) reviewed with window coverings which were in disrepair, were provided privacy while receiving cares. Findings include: R42's quarterly Minimum Data Set (MDS) dated 9/22/15, indicated R42's diagnoses included: traumatic brain injury, depression and pain. The MDS also indicated R42 had severely impaired cognition and required extensive assistance with activities of daily living (ADL's). During observation on 10/28/15, at 10:41 a.m., conducted in R42's room, nursing assistant (NA)-D and licensed practical nurse (LPN)-C transferred R42 onto the bed, removed his pants and incontinent product, then proceeded to provide personal cares. During cares R42's door and vertical blind was closed, however, the blind was missing an entire section which created a 4 inch gap. A hanging privacy curtain was	F 164	Resident #42 blinds were replaced on October 30, 2015. Resident #46 blinds were replaced on October 30, 2015. This has the potential to affect all residents, but none have shown any ill effects. All resident rooms were audited on November 24, 2015 to check the condition of their blinds. All room blinds will be audited weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly by Maintenance Department. Education will be done with nursing staff on privacy and dignity of residents and make out a maintenance slip if they see repairs are needed. Maintenance department will correct the issue.	

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F 164	Continued From page 2 observed in R42's room while he was provided assistance with personal cares, but was not used during cares. During cares, R42's lower half of body was visible to anyone in the parking lot located directly outside of R42's ground level bedroom window. There were no other window coverings which would ensure full visual privacy for R42 in the room. R46's admission MDS dated 8/14/15, indicated R46's diagnoses included: anxiety, diabetes mellitus and chronic pain. The MDS also indicated R46 had moderate impaired cognition and required assistance with dressing and toileting. During observation on 10/27/15, at 10:25 a.m. six sections of the vertical window blinds in R46's room was observed to be missing, which created a 24 inch gap when the blind was closed. There were no other window coverings which would ensure full visual privacy for R46 in the room. On 10/27/15, at 10:25 a.m. R46 stated the blind in his room was in poor shape, missing several pieces since he moved into the room in August. R46 stated he had no privacy when he got dressed and ended up "mooning" people in the parking lot every night. R46 stated he had reported his concerns to the maintenance staff, and was told the facility did not have money in the budget to replace his blind. R46 reported maintenance staff had come to his room to look at the blind, pulled it back and forth and said they didn't have any extra panels to fix it. R46 stated in order to have privacy he would have to get a blanket and hammer it to the wall. R46 stated the parking lot located directly outside of his ground	F 164	It is the responsibility of the Administrator, or designee, to ensure compliance. Findings from the audits will reviewed at the QAA monthly meetings x 3 months.	

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F 164	Continued From page 3	F 164		

level bedroom window was always busy, and stated the parking lot was used for the apartment complex next door. R46 stated there was a person that parked at the very edge of the parking lot near his window to pick someone up every night.

On 10/28/15, at 1:03 p.m. housekeeping (H)-A confirmed the blinds in R42 and R46's room were in disrepair with missing sections. H-A stated the blinds needed to be taken down and replaced. H-A stated R46 had told her people in the parking lot look at him through his window. H-A confirmed the broken blinds have been reported to the maintenance department.

On 10/29/15, at 10:21 a.m. NA-D stated R42 and R46 both had blinds in disrepair, which resulted in a lack of privacy for personal cares. NA-D confirmed the missing panels of both vertical blinds had been reported to maintenance staff several times.

An environmental tour was conducted on 10/29/15, at 4:27 a.m. maintenance (M)-A stated he was aware of R42's missing blind, and had just fixed it today, and confirmed R46's blind was still missing 6 sections of the blind. M-A confirmed R46 verbally requested to him to have his blind repaired in the past. M-A was unable to identify if he had followed up on R46's request to have his blind repaired. M-A stated the facility could not find all of the missing sections for R42 and R46's blind, and stated the blinds were so old that he had no idea what company even made the blinds. M-A reported all of the blinds were different lengths, which made it hard to fix the blind if the missing pieces could not be found. M-A stated it might be down to the point of having

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F 164	Continued From page 4 to replace the blinds. During interview on 10/29/15, at 4:12 p.m., the director of nursing (DON) stated she was not aware of the missing sections in R42 and R46's blinds. The DON stated she did not get down to the rooms very often, but would expect all residents to have intact blinds for privacy. During interview on 10/29/15, at 4:27 p.m. the administrator stated she was surprised and was not aware of the missing sections in R42 and R46's blinds. The administrator stated the facility would replace R46's blind the next day. The facility's Privacy and Confidentiality Policy dated April 1, 2008, indicated all residents would be treated with consideration and respect and full recognition of his/her dignity and individuality, including privacy in treatment and in care for personal needs.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225		12/8/15

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F 225	Continued From page 5 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an incident of potential abuse/neglect to the administrator and to the State Agency (SA) and failed to conduct a thorough investigation of an injury of unknown origin for 2 of 2 residents (R10, R98) reviewed for potential abuse/neglect. Findings include: R10's quarterly Minimum Data Set (MDS) dated 9/30/15, identified R10 had diagnoses which included hemiplegia and hemiparesis, muscle weakness, and major depressive disorder. The	F 225	Resident R10 still resides in the facility with no ill effect for lack of reporting. Resident #98 has been discharged to home. This has the potential to affect all residents, but none have shown any ill effects. Progress noted for resident #10 are regularly reviewed by DON/ designee with follow up as indicated.	

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F 225	Continued From page 6 MDS identified R10 had severe cognitive impairment and required extensive assistance with toileting, transferring and bed mobility. Review of R10's nursing progress notes from 9/18/15 to 9/24/2015, revealed on 9/20/15 R10 stated "that girl is going to get a black eye" and R10 reported a girl was rough with his scrotum during personal cares, stated "it felt like she was hitting them." On 9/21/15, a note identified R10 had complained of staff hurting him and had threatened to give them a black eye. No further documentation regarding the incident was found in R10's record. On 10/29/2015, at 11:12 a.m. the administrator stated she was not aware of the incident with R10. The administrator verified the incident should have been investigated, the resident and nursing staff working at that time should have been interviewed and a report made to the SA if substantiated, if unsubstantiated the resident would have been talked to to see why he felt this way. The administrator stated,"[the facility] "would not report unless we found that staff was threatening." The administrator indicated the management staff met daily to review documentation for incidents, falls and behaviors. The administrator stated she would expect a resident would reviewed for usual behaviors, and depending upon the circumstance, a decision to investigate first or to report to the SA and then investigate, would be made. The administrator indicated she would expect the nursing assistant to be removed from working and the incident would be investigated and then reported On 10/29/15, at 11:20 the director of nursing (DON) confirmed the usual facility practice for	F 225	Progress notes for all residents are reviewed every workday regularly to assess if a VA situation has been warranted, by DON and or designee and follow up done if needed. This will continue every workday indefinitely. All incidents will be discussed in clinical stand-up daily for the team to discuss and decide if reporting is necessary. Nursing staff have all been educated on the need for reporting VA, injury of unknown origin, abuse and neglect, and when investigations are needed, have been given instruction on how to file it via web based reporting. They have been instructed on reporting to the Administrator and DON or designee if the situation develops. System will be monitored in daily standup meetings to ensure correction is achieved and sustained. VA reports will be audited 1 time per month, x 3. It is the responsibility of Administrator, or designee, to ensure compliance. The audit will be reviewed monthly times 3 months in the QAA committee meeting.	

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F 225	Continued From page 7 potential resident abuse. R98's quarterly Minimum Data Set (MDS) dated 8/27/15 identified R98 had severe cognitive impairment and required extensive staff assistance for all activities of daily living (ADLs). The MDS further indicated R98 had diagnoses of diabetes and hypertension. Review of R98's progress notes revealed a note dated 9/24/15 which indicated staff found a bruise on the right lateral side of R98's chest next to his nipple area and measured approximately 7 centimeters (cm) by 4 cm. R98 was unable to express how the bruise may have happened. Staff felt the bruise might have been caused from the pal(mechanical) lift. On 10/28/15, at 4:37 p.m. DON stated it was not facility practice to investigate bruises. She stated R98 had severe cognitive impairment and would not be able to say what happened. She stated they did not know how R98's bruise happened or when it happened and stated the facility had not investigated or reported R98's bruising to the SA but should have. The DON stated she wasn't sure if the bruise had been immediately reported to the administrator. On 10/29/15, at 9:25 a.m. clinical nurse manager (CNM-A) she felt R98's bruising did not meet the criteria to be reported to the SA, but stated it should have been. She stated she was aware of the bruising and stated the DON and the administrator would have been verbally notified during their morning meeting either that day or the next. She confirmed R98 would not be able	F 225		

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F 225	Continued From page 8 to report what happened because his cognition was very poor and stated there was not an incident report filled out for R98's bruise, or an investigation completed for R98's bruise, but there should have been. On 10/29/15, at 9:58 a.m. during follow up interview CNM-A stated she felt the lift straps went under R98's arm and across his chest and the clips must have pinched him. She stated staff were supposed to clip the straps tight to prevent R98 from falling from the lift, and staff were told to be careful not to pinch him. On 10/29/15, at 9:46 a.m. the administrator stated depending on what time R98's bruise happened she would have known about at their morning meeting that day or the next day. She stated the facility did not report R98's bruise to the SA as an injury of unknown origin because they felt they knew what happened. The facility policy Abuse Prevention/Resident Treatment, dated 4/1/08 identified it was the policy of the facility to report injuries of unknown source immediately to the administrator of the facility and the SA. The policy further identified the facility would investigate the incident thoroughly and notify the administrator and the SA of their findings. The policy also identified an injury of an unknown source was an injury that was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 226		12/8/15

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F 226	Continued From page 9 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the abuse prevention policy to ensure injuries of unknown origin was immediately reported to the administrator and the State Agency (SA), and failed to complete a thorough investigation for 2 of 2 residents (R10, R98) reviewed for potential abuse/neglect. Findings include: The facility policy Abuse Prevention/Resident Treatment, dated 4/1/08 identified it was the policy of the facility to report injuries of unknown source immediately to the administrator of the facility and the SA. The policy further identified the facility would investigate the incident thoroughly and notify the administrator and the SA of their findings. The policy also identified an injury of an unknown source was an injury that was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury. R10's quarterly Minimum Data Set (MDS) dated 9/30/15, identified R10 had diagnoses which included hemiplegia and hemiparesis, muscle weakness, and major depressive disorder. The MDS identified R10 had severe cognitive impairment and required extensive assistance with toileting, transferring and bed mobility. Review of R10's nursing progress notes from	F 226	R10 continues to reside in the facility with no ill effect. Resident #98 has been discharged to home. This has the potential to affect all residents, but none have shown any ill effects. Progress noted for resident #10 are regularly reviewed by DON/ designee with follow up as indicated. Progress notes for all residents are reviewed every workday regularly to assess if a VA situation has been warranted, by DON and or designee and follow up done if needed. This will continue every workday indefinitely. All incidents will be discussed in clinical stand-up daily for the team to discuss and decide if reporting is necessary. Nursing staff have all been educated on the need for reporting VA, injury of unknown origin, abuse and neglect, and when investigations are needed, have been given instruction on how to file it via web based reporting. They have been instructed on reporting to the Administrator and DON or designee if the situation develops.	

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F 226	Continued From page 10 9/18/15 to 9/24/2015, revealed on 9/20/15 R10 stated "that girl is going to get a black eye" and R10 reported a girl was rough with his scrotum during personal cares, stated "it felt like she was hitting them." On 9/21/15, a note identified R10 had complained of staff hurting him and had threatened to give them a black eye. No further documentation regarding the incident was found in R10's record. On 10/29/2015, at 11:12 a.m. the administrator stated she was not aware of the incident with R10. The administrator verified the incident should have been investigated, the resident and nursing staff working at that time should have been interviewed and a report made to the SA if substantiated, if unsubstantiated the resident would have been talked to to see why he felt this way. The administrator stated,"[the facility] "would not report unless we found that staff was threatening." The administrator indicated the management staff met daily to review documentation for incidents, falls and behaviors. The administrator stated she would expect a resident would reviewed for usual behaviors, and depending upon the circumstance, a decision to investigate first or to report to the SA and then investigate, would be made. The administrator indicated she would expect the nursing assistant to be removed from working and the incident would be investigated and then reported On 10/29/15, at 11:20 the director of nursing (DON) confirmed the usual facility practice for potential resident abuse.	F 226	Policy on VA and abuse/neglect will be reviewed, implemented, and followed. Employees will be educated on VA and abuse/neglect and reporting as such to the State. All incidents will be monitored and discussed in morning standup and logged for compliance. Audits will be done monthly x 3 months. It is the responsibility of the Administrator, and/or designee, to ensure compliance. Logged incidents will be reviewed and discussed in monthly QA times 3 months.	

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F 226	Continued From page 11	F 226		

R98's quarterly Minimum Data Set (MDS) dated 8/27/15 identified R98 had severe cognitive impairment and required extensive staff assistance for all activities of daily living (ADLs). The MDS further indicated R98 had diagnoses of diabetes and hypertension.

Review of R98's progress notes revealed a note dated 9/24/15 which indicated staff found a bruise on the right lateral side of R98's chest next to his nipple area and measured approximately 7 centimeters (cm) by 4 cm. R98 was unable to express how the bruise may have happened. Staff felt the bruise might have been caused from the pal(mechanical) lift.
On 10/28/15, at 4:37 p.m. DON stated it was not facility practice to investigate bruises. She stated R98 had severe cognitive impairment and would not be able to say what happened. She stated they did not know how R98's bruise happened or when it happened and stated the facility had not investigated or reported R98's bruising to the SA but should have. The DON stated she wasn't sure if the bruise had been immediately reported to the administrator.
On 10/29/15, at 9:25 a.m. clinical nurse manager (CNM-A) she felt R98's bruising did not meet the criteria to be reported to the SA, but stated it should have been. She stated she was aware of the bruising and stated the DON and the administrator would have been verbally notified during their morning meeting either that day or the next. She confirmed R98 would not be able to report what happened because his cognition was very poor and stated there was not an incident report filled out for R98's bruise, or an investigation completed for R98's bruise, but

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 12 there should have been. On 10/29/15, at 9:58 a.m. during follow up interview CNM-A stated she felt the lift straps went under R98's arm and across his chest and the clips must have pinched him. She stated staff were supposed to clip the straps tight to prevent R98 from falling from the lift, and staff were told to be careful not to pinch him. On 10/29/15, at 9:46 a.m. the administrator stated depending on what time R98's bruise happened she would have known about at their morning meeting that day or the next day. She stated the facility did not report R98's bruise to the SA as an injury of unknown origin because they felt they knew what happened. The facility policy Abuse Prevention/Resident Treatment, dated 4/1/08 identified it was the policy of the facility to report injuries of unknown source immediately to the administrator of the facility and the SA. The policy further identified the facility would investigate the incident thoroughly and notify the administrator and the SA of their findings. The policy also identified an injury of an unknown source was an injury that was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241		12/8/15

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	245581	A. BUILDING _____ B. WING _____	10/29/2015

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F 241	Continued From page 13 by: Based on observation, interview and document review, the facility failed to provide cares in a manner which promoted dignity for 2 of 2 resident (R25, R42) observed during morning cares. Findings include: R25's quarterly Minimum Data Set (MDS) dated 9/24/15, identified R25 had severe cognitive impairment. The MDS identified R25 required extensive assistance from staff for personal hygiene, dressing, toileting and transferring. R25's current facility diagnoses list identified diagnoses which included osteoporosis, heart failure, weakness, malaise, cataracts, atherosclerosis, and low back pain. On 10/28/2015, at 8:07 a.m. R25's bedroom window blinds and privacy curtain remained open. A white full size van was parked directly outside of R25's window with the wind shield wipers on through out the observation. R25 sat on the edge of the bed, R25's buttocks was bare and a brief and pants were down on her legs, at the level of her knees. NA-D assisted R25 to donn a tan sweater, then applied a gait belt around R25's waist. R25's buttocks remained bare, with a brief and pants at knee level. R25's window blinds remained open and the privacy curtain not used. NA-D confirmed the window blinds had been open and the privacy curtain had not been used while she assisted R25 with personal cares and closed the window blinds on R25's window at that time. She proceeded to pivot transfer R25 into a wheelchair and wheeled her into the bathroom. R25's brief and pants remained at knee level, with her buttocks bare throughout the transfer	F 241	R25 privacy curtains and blinds are closed with personal cares. R42 instructions for positioning were taken down 10/28/15. R42 no longer shaves in the hallway. This has the potential to affect all residents, but none have shown any ill effects. Nursing staff will be educated on Dignity and Privacy of residents. Nursing staff will be educated that shaving and personal cares should be done in the room or the shower room for privacy and dignity, and all personal cares such as toileting, ect. need to be private. Dining rooms will be monitored daily that name tags are being removed between meals by dietary staff. Audits for dignity and privacy during personal cares will be done by DON, and/or designee 4x week x 4 weeks, 3x week x 4 weeks, 2x week for 4 weeks, and then weekly times 4 weeks. It is the responsibility of the DON, and/or designee, to ensure compliance. Results of the audits will be discussed at monthly QAA for three months.	

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F 241	Continued From page 14 onto the toilet. During interview on 10/28/2015, at 12:54 p.m. NA-D verified the blinds and privacy curtain had been left open while undressing R25. NA-D stated "I just forgot to pull the curtain." During interview on 10/29/2015, at 1:57 p.m. the director of nursing (DON) verified staff were expected to provided privacy for residents during dressing. The DON stated "[staff] should have had the curtain closed." R42 was not provided with a private area during personal cares. R42's clinical information was posted on R42's room wall, visible to all who entered the room. R42's quarterly Minimum Data Set (MDS) dated 9/22/15, indicated R42's diagnoses included: traumatic brain injury, depression and pain. The MDS also indicated R42 had severely impaired cognition and required extensive assistance with activities of daily living (ADL's). R42's undated Nurse Aide Care Plan directed staff EA1(extensive assist of 1) for ADL's, utilized a mechanical lift for transfers, and directed staff not to pull on buttocks when turning in bed or chair use turn sheet at all times. On 10/27/15, at 9:13 a.m. R42 was observed in a wheelchair located next to the nurses station. R42 slowly shaved his face with an electric razor, unassisted. Licensed practical nurse (LPN)-C was seated at the desk, working on the computer, while R42 shaved in the general area next to the nurses station. Facility staff were observed to	F 241		

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F 241	Continued From page 15	F 241		

enter the area briefly, and exit while R42 shaved next to the nurses desk. LPN-C did not offer to assist R42 to move to a private area to complete shaving.

On 10/27/15, at 10:30 a.m. R42 had a shared room, and R42's bed was the first bed placed in the room. An undated sign was observed posted on the wall above the right side of R42's bed. The white, 8 x 11 inch paper sign directed staff on specific cares, the black letters spelled out,"when turning and repositioning resident please make sure to use soaker pad and draw sheet." The sign was visible to all who entered the room.

On 10/28/15, at 1:35 p.m. nursing assistant (NA)-E stated she was not sure why the sign was posted on the wall by R42's bed, and questioned if the sign was posted on the wall to make certain staff followed the positioning directions. NA-E stated the sign did not need to be posted on the wall, as the specific information was also in the nurse aide care sheets.

On 10/29/15, at 11:13 a.m. nursing assistant (NA)-D stated the electric razors were set out on the nurses station for the residents to use. NA-D stated R42 could not communicate to staff if he preferred to shave in public or not. NA-D reported R42's grooming should have been done privately and stated she would have taken him to his room if she would have seen R42 shaving at the nurses station.

On 10/29/15, at 10:38 a.m. LPN-C reported the sign posted on the wall in R42's room was a "double and triple reminder" to staff on R42's repositioning needs. LPN-C confirmed R42 shared a room with another resident, and verified

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F 241	Continued From page 16 R42's personal care information posted on the wall would be visible to others, including visitors. LPN-C confirmed the posted sign was undignified and stated she would take it down immediately. On 10/29/15, at 4:21 p.m. the director of nursing (DON) stated she was not aware of the posted sign in R42's room, and confirmed the information should not have been posted on the wall. On 10/29/15, at 4:31 p.m. the administrator stated the usual facility practice did not include residents to shave right by the nurses station, and stated shaving by the nurses station was not dignified. The administrator reported staff preferred to supervise R42 during shaving, but should have provided a private place for the task. The facility's Dignity Quality of Life policy dated April 1, 2008, directed staff to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect.	F 241		
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 implement care plan interventions related to toileting for 1 of 3	F 282	Resident R42 is now being toileted per care plan. Residents R42 and R3, are now being repositioned as per the care	12/8/15

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F 282	Continued From page 17 residents (R42), repositioning for 2 of 2 residents (R42,R3) reviewed for pressure ulcers. Findings include: R42's care plan, revised 6/24/15, indicated R42 had a fissure (thin linear opening of the skin) between buttocks, was at risk for pressure ulcer development related to immobility and incontinence. R42's care plan identified R42 was to repositioned every two hours while in the wheelchair and every four hours while in bed and was on a check and change program with rounds and as needed. Review of the undated Nurse Aide Care plan which nursing assistant (NA)-E provided, directed staff to reposition R42 every two hours while in bed and every four hours while in R42's wheelchair. During continuous observation on 10/28/15, from 7:08 a.m. to 10:10 a.m. R42 sat in a wheelchair with both feet placed on the foot pedals. During observation R42 repeatedly moved his upper body back in forth while in the wheelchair but R42's lower body remained in the same position in the wheelchair. - 7:41 a.m. staff assisted R42 into the dining room and pushed R42's wheelchair up to the dining room table, R42 remained at the breakfast table until 9:02 a.m. At that time staff pushed R42's wheelchair out of the dining room and into the hallway. -9:41 a.m. R42 remained in the hallway, until 9:46 a.m., when R42 propelled the wheelchair slowly to the nurses station. R42 leaned forward,	F 282	plan. This has the potential to affect all residents, but none have shown any ill effects. Resident #42 bowel and bladder status has been reviewed and care plan updated to reflect current interventions. Resident #42 is receiving cares directed from the care plan. Resident #3 repositioning and pressure ulcer risks and prevention have been reviewed and resident #3 is being repositioned and toileted as directed from the care plan. Care plans of all other residents have been reviewed and revised if indicated. CNA pocket care plans have been reviewed to ensure accuracy according to individual care plans. CNA cares will be monitored for compliance with the turning and repositions schedules and toileting schedules by DON/Designee. Nursing staff will be reeducated on following the care plan pertaining to turning and toileting. Care plans will be updated as needed with Change of Condition, quarterly, and the CNA care plan updated as needed. Care plans of new admits will be done on admit, with change of Condition and with quarterly assessments.	

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F 282	Continued From page 18 moaned and placed his right hand on top of the counter at the nurse station. Facility staff were present at the nurses desk and did not offer to reposition R42. -9:56 a.m. R42 remained in the wheelchair located next to the nurses station, multiple staff members including nursing assistants and nurses walked by R42 without offering cares or repositioning. On 10/28/15, at 10:08 a.m. NA-E stated she was aware R42 had not been repositioned for 3 hours and stated she would reposition R42 in a few minutes. NA-E stated R42 required extensive assistance of two for positioning and R42 was incontinent of urine and bowel. NA-E stated staff were to check and change R42's incontinent product during rounds every two hours if they could get to it, and transfer R42 to the toilet once per day. NA-E confirmed it had been at least three hours when R42 received repositioning and toileting cares on 10/28/15, she reported staff were not always able to get basic cares done timely due to lack of staff working. -10:10 a.m. NA-E and NA-D transferred R42 with a mechanical lift from the wheelchair to the toilet. NA-E removed R42's incontinent product which was wet with urine. A fissure was observed on R42's coccyx (medial aspect of buttocks, towards crease,) uncovered with no dressing in place. R42's buttocks skin area appeared very red surrounding the fissure. NA-E stated R42 usually had a dressing on the fissure and was surprised it wasn't in place. At 10:15 a.m. NA-E and NA-D assisted R42 to transfer back to the wheelchair. NA-D indicated she would report R42's missing dressing to the nurse.	F 282	Observational Audits to monitor compliance of care with toileting and repositioning will be done by DON/Designee will be 4x a week for 4 weeks, 3x a week for 4 weeks, and then 2x a week for 4 weeks, and then weekly x 4. It is the responsibility of the DON, or designee, to ensure compliance. Results of audits will be discussed in the QAA meetings monthly times 3 months.	

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On 10/28/15, at 10:24, a.m. CNM-B confirmed R42's tissue tolerance test and confirmed the care plan directed R42 to be repositioned every two hours while in the chair, and be toileting every two hours.

On 10/28/15, at 11:29 a.m. the director of nursing (DON) stated the facility needed to improve the wound program, and confirmed she expected staff to reposition R42 every two hours while in the chair and provide toileting every two hours as directed in the care plan.

R3 had not been repositioned from 9:04 a.m. until 1:01 p.m., a total of 3 hours and 57 minutes. R3 was unable to preposition herself independently and was not assisted by staff to be repositioned every two hours per her current care plan.

R3's current care plan dated 9/12/15, directed staff to change R3's position every two hours while in bed, while in wheel chair and as needed with extensive assist of two staff to reposition.

Review of Nurse Aid Care Plan directed staff to turn and reposition R3 every two hours with extensive assistance of two staff using EZ way lift and cloth turn sheet.

During observation on 10/28/15 at 9:13 a.m. nursing assistant (NA)-A and NA-B assisted R3 into a purple colored reclining wheelchair via total mechanical lift after morning cares were

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F 282	Continued From page 20	F 282		

completed. NA-A proceeded to push R3's wheelchair to the sitting room across from the nurses station on the main floor for the breakfast meal. At 9:50 a.m. R3 remained seated at the table, eating her breakfast.

During continual observation on 10/28/15 at 12:26 p.m. to 1:01 p.m., R3 was seated in the main dining room eating her lunch independently, she was slightly leaning to the left in her wheelchair and stated "my butt hurts." R3 stated she had not been repositioned or laid down after breakfast and indicated she had been in her wheelchair all morning. At 12:38 p.m. a facility staff member approached R3 and wheeled her into her room. R3 remained seated in her wheelchair until 1:01 p.m. NA-B and NA-C assisted R3 to transfer from the wheelchair into her bed at 1:01 p.m.

On 10/28/15 at 1:16 p.m. NA-A confirmed R3 had not been transferred from the wheelchair or repositioned since R3 had been assisted into the wheelchair for the breakfast meal. She indicated she had tilted R3's wheelchair back to relieve pressure off of R3's legs, but had not completed offloading for R3.

On 10/29/15 at 1:45 p.m. director of nursing confirmed R3 was to be repositioned every two hours while in bed and in her wheel chair per her current care plan. DON verified tilting R3's wheelchair back only redistributes the weight to another area. The DON also verified that this was not good protocol and stated staff should be getting R3 out of the wheelchair up, not tilting R3's wheelchair back. The DON also stated she would expect staff to follow the plan of care.

Review of the facility policy titled Resident Care

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F 282	Continued From page 21 Plan Policy and Procedure, reviewd 12/21/11, revealed each resident's care plan would be devoloped to meet the needs of the individual resident.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an unhealed skin fissure was assessed, monitored and interventions implemented for 1 of 3 residents (R42) reviewed for non-pressure related skin conditions. Findings include: R42's quarterly Minimum Data Set (MDS) dated 9/22/15, indicated R42's diagnoses included: traumatic brain injury, depression and pain. The MDS further indicated R42 had severely impaired cognition and required extensive assistance with activities of daily living (ADL's). R42's care plan, revised 6/24/15, indicated R42 had a fissure between buttocks, was at risk for pressure ulcer development related to immobility and incontinence. R42's care plan identified R42	F 309	Resident R42 is being repositioned as indicated in the plan of care. The fissure to R42 is continuing to heal. This has the potential to affect all residents, but none have shown any ill effects. Resident #42 skin fissure has been assessed, and is monitored, and measured weekly. Appropriate interventions for resident #42 have been reviewed and implemented. Care plan has been reviewed and updated as indicated. Other residents with non pressure skin conditions are being assessed and monitored with appropriate interventions	12/8/15

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F 309	Continued From page 22 was to repositioned every two hours while in the wheelchair and every four hours while in bed. During continuous observation on 10/28/15, from 7:08 a.m. to 10:10 a.m. R42 sat in a wheelchair with both feet placed on the foot pedals. During observation R42 repeatedly moved his upper body back in forth while in the wheelchair but R42's lower body remained in the same position in the wheelchair. - 7:41 a.m. staff assisted R42 into the dining room and pushed R42's wheelchair up to the dining room table, R42 remained at the breakfast table until 9:02 a.m. At that time staff pushed R42's wheelchair out of the dining room and into the hallway. -9:41 a.m. R42 remained in the hallway, until 9:46 a.m., when R42 propelled the wheelchair slowly to the nurses station. R42 leaned forward, moaned and placed his right hand on top of the counter at the nurse station. Facility staff were present at the nurses desk and did offer to reposition R42. -9:56 a.m. R42 remained in the wheelchair located next to the nurses station, multiple staff members including nursing assistants and nurses walked by R42 without offering cares or repositioning. On 10/28/15, at 10:08 a.m. nursing assistant (NA)-E stated she was aware R42 had not been repositioned for 3 hours and stated she would reposition R42 in a few minutes. -10:10 a.m. NA-E and NA-D transferred R42 with a mechanical lift from the wheelchair to the toilet.	F 309	in place. All residents will have a Braden done on Admit, with Change of Condition, and with Quarterly MDS. Results will be discussed by care team to implement preventive measures as needed. All skin and wound issues will be assessed weekly per protocol, and charted on as such. Nursing will be education on skin care/assessments, and repositioning per care plan. A weekly wound and skin meeting will be held to assess treatments and progress of skin and wound issues. This team will include Dietary, Activities, Social Services, DON, Unit Managers, and Administrator when available. To assure that the facility correction is sustained, weekly monitoring and auditing of all new admissions will be done by DON, and/or designee, for compliance that all preventive measures are in place for those at high risk for skin breakdown. It is the responsibility of the DON, and/or designee, to ensure compliance. Reports on skin issues will be covered and monitored at the facilities QAA committee monthly meetings x 3 months.	

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F 309	Continued From page 23	F 309		

NA-E removed R42's incontinent product which was wet with urine. A thin linear opening (fissure) was observed on R42's coccyx ,uncovered with no dressing in place. R42's buttocks area appeared very red surrounding the fissure. NA-E stated R42 usually had a dressing on the fissure and was surprised it wasn't in place. At 10:15 a.m. NA-D and NA-E assisted R42 to transfer back to the wheelchair. NA-D indicated she would report R42's missing dressing to the nurse.

Review of the undated Nurse Aide Care plan which NA-E provided, directed R42 to reposition every two hours while in bed and every four hours while in R42's wheelchair.

Review of R42's Tissue tolerance data collection sheet(TT),(tool to determine needed pressure redistribution) dated 3/21/15, for wheelchair/chair identified no increased redness at bony prominence's, with 2 hr check in wheelchair. The form identified after four hours, while positioned in the chair, R42's upper thighs had increased pinkness which had dissipated after offloading pressure, and identified a chronic fissure on the coccyx. R42's TT For Bed identified R42's skin had no redness after 4 hours of lying. The form directed to use a different cushion in the wheelchair or less time in the chair.

R42's TT dated 6/16/15 indicated no skin redness noted to bony prominence's after four hours positioned in chair and in bed, identified R42 had a chronic fissure to coccyx and identified to continue current interventions.

Review of R42's physician progress note dated 2/17/15, indicated R42 had a fissure on the anal

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	245581	A. BUILDING _____ B. WING _____	10/29/2015

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

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F 309	Continued From page 24 crest. The note did not include any identified interventions or changes orders to treat the fissure. Review of nurses notes from 4/10/15 through 10/29/15 indicated the following: -4/10/15, fissure site approximately 1 centimeter(cm) in length with noted depth -5/29/15, fissure appears wider in appearance and deeper with dark red appearance and inner open area -6/1/15, continues with fissure to coccyx, noted a dime size mount of bright red blood in R42's brief, treatment applied. Nurse practitioner assessed fissure site, requested an evaluation for wheel chair cushion -6/3/15, fissure appeared larger and deeper in appearance -7/27/15, coccyx fissure longer in size and depth -8/3/15, fissure appears to be smaller with Aquacel Ag(dressing imbedded with silver) usage -10/6/15, continues with a dry, deep red fissure area R42's nurses notes included documentation the dressing changes were being done, however, lacked documentation of any further effectiveness of current interventions or any needed changes in interventions. R42's medical record lacked any further skin assessments or skin audits that identified the ongoing fissure's size and description and interventions. On 10/28/15, at 10:08 a.m. NA-E stated R42's Nurse Aide Care Plan directed staff to reposition every two hours when in bed and every four hours when in chair, and confirmed the repositioning schedule for R42 had not changed	F 309		

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in the recent past. NA-E stated R42 required extensive assistance of two for positioning and toileting, and reported R42 was incontinent of urine and bowel. NA-E stated staff were to check and change R42's incontinent product every two hours if they could get to it, and transfer R42 to the toilet once per day. NA-E reported R42 had the fissure on his coccyx for a long time, but could not recall when or how he acquired it. NA-E confirmed it had been at least three hours when R42 received repositioning and toileting cares on 10/28/15, she reported staff were not always able to get basic cares done timely due to short staffing.

On 10/28/15, at 10:22 a.m. licensed practical nurse (LPN)-C stated R42 was to be repositioned every two hours while in the chair and every four hours when in bed, and toileted every two hours. LPN-C confirmed NAs utilize the Nurse Aide Care Plan to direct resident care and should match R42's care plan. LPN-C confirmed R42's Nurse Aide Care Plan was incorrect related to R42's repositioning schedule. Clinical nurse manager (CNM)-B confirmed R42's repositioning in bed and the chair schedule on the Nurse Aid Care Plan were incorrect. LPN-C stated R42 currently had a fissure near the coccyx, and indicated the dressing should be in place at all times. LPN-C indicated she was not aware the dressing in the fissure was not in place for R42. LPN-C reported she did not feel the dressing was effective, as it often fell out of the fissure She stated she had not updated R42's physician or nurse practitioner with her concerns. At 10:43 a.m. after LPN-C had completed the new dressing application, she stated R42's fissure measured 0.3 cm x 0.2 cm x 0.2 cm.

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On 10/28/15, at 10:24, a.m. CNM-B confirmed R42's TT and confirmed the care plan directed R42 to be repositioned every two hours while in the chair, and be toileting every two hours. At 10:55 a.m. CNM-B confirmed the facility did not routinely measure R42's fissure. CNM-B confirmed the facility did not collect data on the fissure to determine if the current treatment was effective, and stated the last measurement completed by staff was on 2/19/15. She stated the facility conducted visual inspection of R42's wound.

On 10/29/15, at 9:14 a.m. nurse practitioner (NP)-A stated the wound on R42's coccyx was a fissure and was not sure how the fissure developed. She indicated the fissure could have been do to repositioning, sliding down in bed or buttocks could have been caught on the commode. NP-A stated the fissure originally started out very superficial and had increased in size over time. NP-A stated she changed the dressing type in the past and confirmed the dressing should be in place at all times, and changed every day and as needed. NP-A stated if the dressing had not been staying in place, she expected facility staff to update her so she could consider a different treatment. NP-A stated she visited R42 every six months and relied on staff to update her if R42's fissure changed in size or appearance. NP-A understood facility staff had been routinely measuring the fissure, and confirmed staff had not updated her on the size of the fissure.

On 10/28/15, at 11:29 a.m. the director of nursing (DON) stated the facility needed to improve the wound program, and confirmed the facility had not been measuring R42's fissure and would only

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F 309	Continued From page 27 expect routine measurements be completed on pressure ulcers. The DON confirmed the facility had not been conducting the weekly interdisciplinary team meetings. The DON confirmed she expected staff to reposition R42 every two hours while in the chair and provide toileting every two hours as directed in the care plan. The facility's Pressure Ulcers/Skin Integrity/Wound Management policy dated 9/13/11, indicated a system was in place to prevent, identify, treat pressure and non-pressure wounds. The policy indicated non-pressure wounds would be routinely measured at least weekly and documented, and reviewed at the weekly interdisciplinary team meeting.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence for 1 of 3 residents (R42) dependant upon staff for personal cares. Findings include: R42's quarterly Minimum Data Set (MDS) dated 9/22/15, indicated R42's diagnoses included:	F 312	R42 is being toileted and checked for toileting needs as per the care plan. This has the potential to affect all residents, but none have shown any ill effects. Resident #42 bowel and bladder status has been reviewed and care plan updated	12/8/15

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F 312	Continued From page 28 traumatic brain injury, depression and pain. The MDS further indicated R42 had severely impaired cognition and required extensive assistance with ADL's. Further, the MDS identified R42 was frequently incontinent of urine, and a toileting program had not been attempted since incontinence had been noted in the facility. R42's bowel and bladder assessment dated 10/12/15 indicated R42 was incontinent of urine and bowel and was unable to voice an urge to void. The assessment indicated R42 had a fissure between anus and coccyx and required total assistance with a mechanical lift for toileting and personal cares. R42's care plan revised on 6/24/15, indicated R42 was frequently incontinent of bladder and bowel, required extensive assist of two for toileting and hygiene tasks, had functional incontinence and was on a check and change program with rounds and as needed. Review of the undated Nurse Aide Care plan, provided by NA-E, indicated R42 was to repositioned every two hours while in bed and every four hours while in the wheelchair, and incontinent product checked and changed with rounds and as needed. During continuous observation on 10/28/15, from 7:08 a.m. to 10:10 a.m. R42 sat in a wheelchair with both feet placed on the foot pedals. During observation R42 repeatedly moved his upper body back in forth while in the wheelchair. - 7:41 a.m. staff assisted R42 into the dining room and pushed R42's wheelchair up to the dining room table, R42 remained at the breakfast	F 312	to reflect current interventions. Care plans of all other residents have been reviewed and revised as indicated. All residents will be assessed for toileting needs and turning schedules when admitted to facility, a change of condition, and with quarterly assessment. All ADL's will be assessed for need of extent of assistance required. All care plans will be compared to the CNA care plan to assure they coincide. Education will be done for nursing staff to go over repositioning and skin care compliance with facility policy and procedure. To ensure facility is sustaining the changes made for compliance, audits of turning and toileting schedules will be done 4x weekly xc 4, then 3x weekly x 4, then 1x weekly times 4 weeks. If is the responsibility of the DON, and/or designee, to ensure compliance. Results of audits will be discussed at the monthly QAA meeting times 3 months.	

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table until 9:02 a.m. At that time staff pushed R42's wheelchair out of the dining room and into the hallway.

-9:41 a.m. R42 remained in the hallway, until 9:46 a.m., when R42 propelled the wheelchair slowly to the nurses station. R42 leaned forward, moaned and placed his right hand on top of the counter at the nurse station. Facility staff were present at the nurses desk and did not offer to reposition R42.

-9:56 a.m. R42 remained in the wheelchair located next to the nurses station, multiple staff members including nursing assistants and nurses walked by R42 without offering cares or repositioning.

On 10/28/15, at 10:08 a.m. nursing assistant (NA)-E stated she was aware R42 had not been repositioned for 3 hours and stated she would reposition R42 in a few minutes.

-10:10 a.m. NA-E and NA-D transferred R42 with a mechanical lift from the wheelchair to the toilet. NA-E removed R42's incontinent product which was wet with urine. A thin linear opening (fissure) was observed on R42's coccyx ,uncovered with no dressing in place. R42's buttocks area appeared very red surrounding the fissure. NA-E stated R42 usually had a dressing on the fissure and was surprised it wasn't in place. At 10:15 a.m. NA-D and NA-E assisted R42 to transfer back to the wheelchair.

On 10/28/15, at 10:08 a.m. NA-E stated R42 required extensive assistance of two for positioning and R42 was incontinent of urine and bowel. NA-E stated staff were to check and

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F 312	Continued From page 30 change R42's incontinent product during rounds every two hours if they could get to it, and transfer R42 to the toilet once per day. NA-E confirmed it had been at least three hours when R42 received repositioning and toileting cares on 10/28/15, she reported staff were not always able to get basic cares done timely due to lack of staff working. On 10/28/15, at 10:22 a.m. licensed practical nurse (LPN)-C reported R42 was to be repositioned every two hours while in the chair and toileted every two hours. LPN-C stated the nursing assistants utilize the Nurse Aide Care Plan to direct resident care and were printed every shift, and should match R42's care plan. On 10/28/15, at 10:24, a.m. clinical nurse manager (CNM)-B confirmed R42's care plan directed R42 to be repositioned every two hours while in the chair and be toileted every two hours. On 10/28/15, at 11:29 a.m. the director of nursing (DON) confirmed staff were expected to reposition R42 every two hours while in the chair and provide toileting cares every two hours as directed in the care plan. The facility's Activity of Daily Living Policy dated 4/1/08, indicated a resident who was not able to carry out ADL's such as transferring and toileting would receive the necessary services to maintain good nutrition, grooming and personal hygiene.	F 312		
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	F 314		12/8/15

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F 314	Continued From page 31 does not develop pressure sores unless the 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 timely repositioning for 1 of 1 resident (R3) identified at risk for pressure ulcers. Findings include: R3's quarterly Minimum Data Set (MDS), dated 9/3/15, identified R3 had moderately impaired cognition, and had diagnoses which included diabetes mellitus, seizure disorder, anxiety and depression. The MDS identified R3 required extensive assist of two staff for bed mobility and was totally dependent on staff for transferring. Furthermore the MDS also indicated R3 was at risk for the development of pressure ulcers and listed various treatments which included turning and repositioning. R3's care area assessment (CAA) dated 3/11/15, identified R3 was at risk for alteration in skin integrity related to incontinence of bowel and bladder, was at risk for development of pressure ulcers and required total dependence of two staff for repositioning and bed mobility. R3's Braden Scale for Predicting Pressure Sore Risk form, dated 8/29/15, identified R3 was at low risk for the development of pressure ulcers, and	F 314	R3 is being repositioned as per the care plan. This has the potential to affect all residents, but none have shown any ill effects. Other residents with or at risk for pressure ulcers have interventions in place and are being repositioned according to the plan of care. All current residents and new residents will have their ability to perform their ADL's assessed on admission, with change of condition and with quarterly assessment. Resident care plans will be updated as needed and CNA care plans updated and followed per facility protocol. Nursing education ill be done on following care plan and updating care plan when needed. Monitoring of the system in place will be done with audits of position of 4 selected residents at high risk for skin issues 4x weekly for 4 weeks, then 3 x weekly for 4 weeks, and then twice weekly for 4	

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F 314	Continued From page 32 indicated R3 was unable to to make frequent or significant changes independently, and could not bear weight. R3's Tissue Tolerance Data Collection Sheet, dated 9/2/15 identified R3's skin was intact currently, and listed staff to reposition every two hours in bed and wheelchair. R3's current care plan dated 9/12/15, directed staff to change R3's position every two hours while in bed, while in wheel chair and as needed with extensive assist of two staff to reposition. Review of Nurse Aid Care Plan directed staff to turn and reposition R3 every two hours with extensive assistance of two staff using EZ way lift and cloth turn sheet. During observation on 10/28/15 at 9:13 a.m. nursing assistant (NA)-A and NA-B assisted R3 into a purple colored reclining wheelchair via total mechanical lift after morning cares were completed. NA-A proceeded to push R3's wheelchair to the sitting room across from the nurses station on the main floor for the breakfast meal. At 9:50 a.m. R3 remained seated at the table, eating her breakfast. During continual observation on 10/28/15 at 12:26 p.m. to 1:01 p.m., R3 was seated in the main dining room eating her lunch independently, she was slightly leaning to the left in her wheelchair and stated "my butt hurts." R3 stated she had not been repositioned or laid down after breakfast and indicated she had been in her wheelchair all morning. At 12:38 p.m. a facility staff member approached R3 and wheeled her into her room. R3 remained seated in her wheelchair until 1:01	F 314	weeks, then weekly times 4 weeks. It is the responsibility of the DON, and/or designee, to ensure compliance is met. Results of audits will be discussed in the monthly QAA meetings x 3 months.	

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F 314	Continued From page 33 p.m. NA-B and NA-C assisted R3 to transfer from the wheelchair into her bed at 1:01 p.m. R3 had not been repositioned from 9:04 a.m. until 1:01 p.m., a total of 3 hours and 57 minutes. R3 was unable to preposition herself independently and was not assisted by staff to be repositioned every two hours per her current care plan. On 10/28/15 at 1:02 p.m. NA-B stated she thought this was the first time R3 has been assisted to bed since the morning, but was unsure if R3 had been repositioned during that time. On 10/28/15 at 1:16 p.m. NA-A confirmed R3 had not been transferred from the wheelchair or repositioned since R3 had been assisted into the wheelchair for the breakfast meal. She indicated she had tilted R3's wheelchair back to relieve pressure off of R3's legs, but had not completed offloading for R3. On 10/28/15 at 1:23 LPN-A confirmed R3 was to be repositioned every two hours and indicated she would expect staff to either assist her to lie down or to offload her routinely. LPN-A verified tilting R3 back in her wheelchair was not repositioning her and stated 'repositioning is moving off her (R3) bottom and getting the pressure off of her (R3) bottom." On 10/28/15 at 1:28 p.m. LPN-B confirmed R3 was to be repositioned every two hours while in bed and in her wheel chair per her current care plan. LPN- B also verified tilting R3 back in her wheelchair was not repositioning her and confirmed she would expect routine offloading to be done.	F 314		

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F 314	Continued From page 34 On 10/28/15 at 1:48 p.m. physical therapist assistant (PTA) and physical therapist (PT) confirmed R3 was to be repositioned every two hours while in bed and in her wheel chair per her current care plan. PT verified tilting R3 back in her wheelchair was not repositioning her and indicated R3 should be offloaded or laid down. On 10/29/15 at 1:45 p.m. director of nursing confirmed R3 was to be repositioned every two hours while in bed and in her wheel chair per her current care plan. DON verified tilting R3's wheelchair back only redistributes the weight to another area. The DON also verified that this was not good protocol and stated staff should be getting R3 out of the wheelchair up, not tilting R3's wheelchair back. The DON also stated she would expect staff to follow the plan of care. Review of facility policy titled, Pressure Ulcers/Skin Integrity/Wound Management revised on 9/13/2011, indicated appropriate turning and repositioning schedules would be put in place per resident assessment. The policy also indicated residents at risk for or who have loss of skin integrity would receive the appropriate treatment/services which include: repositioning or "off-loading" as per resident assessment and careplan.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356		12/8/15

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F 356	Continued From page 35 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nursing hours posting was updated daily to reflect current hours worked. This had the potential to affect all 52 residents who resided in the facility and family / visitors who wished to view this information. Findings include: During the initial tour on 10/26/15, at 12:46 p.m. the nursing hours posting was observed in a	F 356	The facility is now posting daily staffing as required that includes Facility name, the current date, the total number and the actual hours worked by licensed and unlicensed staff directly responsible for resident care. This has the potential to affect all residents, but none have shown any ill effects.	

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F 356	Continued From page 36 plastic sleeve, secured to a wall, directly by the main level nursing station window to the left. The posting included the current resident census, facility name, date, hours of labor and each shift of work for registered nurses (RNs), licensed practical nurses (LPNs), trained medication aid (TMA) and nursing assistants (NAs). However, the posting was dated 8/31/15, and was not updated to reflect the hours worked on 10/26/15. During subsequent observations of the nursing hours posting, the following was identified: On 10/27/15, at 4:00 p.m. nursing hours posting was dated 8/31/15, and was not updated to reflect the hours worked on 10/27/15. On 10/28/15, at 7:41 a.m. and again at 2:30 p.m., nursing hours posting was dated 8/31/15, and was not updated to reflect the hours worked on 10/28/15. On 10/29/15, at 8:30 a.m. and again at 5:00 p.m. nursing hours posting was dated 8/31/15, and was not updated to reflect the hours worked on 10/29/15. On 10/29/15 at 5:14 p.m. administrator confirmed the facility's medical records staff was responsible for updating the nursing hours posting. The administrator verified the medical records staff had resigned and stated "that is why it is not being done, this is my error in not noticing this." The administrator verified the staff posting should of been done on a daily basis to reflect the hours of labor for staff. A policy for posting daily nursing staff was requested on 10/29/15, but one was not provided.	F 356	This posting is being updated daily by medical records and/or charge nurse. The medical records manager, or charge nurse, will post the staffing sheet daily during am shift. Education will be given to charge nurses on weekends on the posting of daily staffing as required. Compliance will be monitored daily in the morning stand up meeting and documentation showing compliance will be filed. Posting audits will be 5x week for 4 weeks, then 1x week for 2 months. If is the responsibility of the DON, and/or designee, to ensure compliance. the results will be discussed in the QAA meeting for three months.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		12/8/15

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 _____	10/29/2015

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

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F 371	Continued From page 37 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dishes were cleaned and stored under sanitary conditions, which had the potential to affect all 53 residents in the facility. Findings include: During the initial kitchen tour on 10/26/15, at 12:54p.m. with cook (C)-A present on tour. Two 15 inch round oscillating fans, both laden with dust, were observed attached to the wall in the dishwashing area. One fan was located on each side of the dishwasher. Both fans were observed with a thick layer of dust buildup on the interior and exterior surfaces. The fan to the left of the dishwasher was observed blowing directly on the cups, plates and bowls as the dishes exited the dishwasher, and also continued to blow directly towards the dishes as the dishes air dried. C-A confirmed the oscillating fans were dirty with dust and blowing directly on the clean dishes. C-A stated the fans usually were cleaned weekly, but due to staff reductions and hours being reduced scheduled maintenance was not being	F 371	Both oscillating fans in the kitchen have been cleaned. This has the potential to affect all residents, but none have shown any ill effects. Fan cleaning will be put on a cleaning schedule to ensure compliance. Audits of fans in dietary will be done daily 5 days a week for 4 weeks, 4 days per week for three weeks, and then twice a week for 4 weeks. After that they will be done weekly. Education for dietary staff for compliance with cleaning schedule. It is the responsibility of the CDM, and or designee, to ensure compliance. Results of audits will be discussed and gone over in the monthly QAA meeting times three months.	

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	245581	A. BUILDING _____ B. WING _____	10/29/2015

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F 371	Continued From page 38 completed. C-A did not shut off the dirty oscillating fan and continued to blow on the clean dishes. C-A stated the fans were not used to assist in drying the dishes, but were used for staff comfort. On 10/29/15, at 1:10 p.m. the assistant dietary manager (ADM) reported due to reduced staffing hours, regular cleaning in the kitchen was now the responsibility of the housekeeping department. ADM confirmed both fans were very dirty with dust and blew directly on clean dishes. The ADM confirmed the fans were used daily for staff comfort. The ADM stated it had been more than a month since the fans had been cleaned last. The ADM was not able to provide documentation of the fan cleanings or the expectations of scheduled cleaning maintenance of kitchen equipment. The ADM stated he took the oscillating fans down to clean after the initial kitchen tour on 10/26/15, confirmed they were very dirty, and stated, he felt the fans need to be cleaned weekly. The facility's Dietary Cleaning Schedule dated 5/6/98, indicated the kitchen was to be thoroughly cleaned three times per year. The policy also identified other items to be cleaned more frequently such as counters, floors and sinks. However, cleaning of the oscillating fans were not included in the policy.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		12/8/15

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F 441	Continued From page 39 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program that included surveillance and investigation of infections that occurred in the	F 441	The facility now has an infection control program that includes surveillance and investigation of infections that occur in the facility.	

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F 441	Continued From page 40 facility. This had the potential to affect all 43 residents currently residing the facility. Findings include: Review of the facility's Monthly Infection Control Log (s) from February 2015, through October 2015, revealed the facility listed various resident infections such as urinary tract infection(UTI), upper respiratory infections, emesis, influenza, skin infections, diarrhea and listed if the resident received antibiotics. However, the log lacked documentation of symptoms, specific organisms, culture results, specific location of residents to identify a possible trend or pattern in infections, and did not include onset of symptoms or infections consistently. The logs had been completed by the floor nurses, and were to be monitored and analyzed for tracking and trending by the clinical nurse managers (CNM); however, the CNMs had not analyzed the data in order to track trends and patterns of the infections within the facility. On 10/29/2015, at 1:09 p.m. Clinical nurse manager (CNM)-A verified infection control logs were kept at each nurses station. CNM-A stated "me and [CNM-B] keep them updated." We report to the DON and she takes to (QA) quality assurance. On 10/29/2015, at 2:09 p.m. CNM-A indicated the usual facility practice was to include residents on the infection control log if the resident received antibiotics. She indicated she would review the logs every 1-2 weeks, and confirmed the logs were updated at times once a month when the	F 441	This has the potential to affect all residents, but none have shown any ill effects. A new procedure for monitoring infections in the facility has been established. Education for staff will be completed for the new procedure. Nursing staff will be educated and a competency done for gloves and hand washing. Unit managers will monitor infection control books/logs on each unit and track information from signs and symptoms and cultures done. DON, or designee, will do an infection control audit once a month x 3 months. Results of the audits will be discussed for trending and tracking in the monthly QAA meetings x 3 months. It is the DON, or designee, who is responsible to ensure compliance.	

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F 441	Continued From page 41 director of nursing requested a list of infections for the months. CNM-A indicated she did not routinely analyze the data on the infection logs. On 10/29/2015, at 2:21 p.m. CNM-B indicated the criteria for documenting on the infection control log was signs of infection, and typically if the resident had been treated with an antibiotic. CNM-B identified the infection control log was reviewed frequently in order to monitor if antibiotic use has been logged and verified the facility did not track symptoms without use of an antibiotic and did not track specific organism results from cultures. On 10/29/2015, at 3:10 p.m. the interim DON identified CMN-A and CNM-B were responsible to track and trend infections for 2 floors of the facility. The DON verified the logs appeared to track antibiotic use and did not have organisms documented. The requested facility policy regarding the infection control program was not provided.	F 441		

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	245581	A. BUILDING **01 - DINING ADDITION 01** B. WING _____	**10/27/2015**

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FAIR OAKS LODGE	**201 SHADY LANE DRIVE WADENA, MN 56482**

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

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

Electronically Signed | 11/24/2015

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.

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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		

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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 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		11/24/15

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K 017	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities residents, staff and visitors. Findings include: On facility tour between 8:30 AM to 1:30 PM on 10/27/2015, it was observed on the main floor east corridor, a ceiling penetration(vertical opening) above the ceiling tile next to the smoke barrier in the 1972 addition This deficient practice was verified by the Maintenance Director.	K 017	The ceiling penetration (vertical opening) above the ceiling tile next to the smoke barrier in the 1972 addition on the main floor east corridor, has been repaired with 3M fire block foam FB block, which meets A5TM E 84 Class 1 specifications required by the Life Safety Code regulations. This was completed on November 24, 2015. This had the potential to affect all residents, but none have shown any ill effects. Monthly maintenance checks of smoke barrier walls will be conducted and immediate repair as needed. It is the responsibility of the Maintenance Director to ensure compliance. Findings of any disrepair and repair of ceiling penetrations will be discussed at the monthly QAA meeting x 3 months.	
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022		11/13/15

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K 022	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 1 of several non-required doors leading to the exterior that do not lead to the public way in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.1.7 and 7.10.8.1 These deficient practices could negatively affect residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 8:30 AM to 1:30 PM on 10/27/2015, observations revealed that the door in the common area that leads to an enclosed courtyard was not labeled as "NO EXIT". This door is not part of a required facility exits and need to display a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO". This deficient practice was verified by the Maintenance Director.	K 022	The door in the common area on lower floor leading out to an enclosed courtyard has been labeled with "NO EXIT" signs as required. This was completed on November 13, 2015. This had the potential to affect all residents, staff and visitors, but no ill effects have been shown. It is the responsibility of the Maintenance Director, or designee, to ensure compliance.	
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average	K 075		12/8/15

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K 075	Continued From page 5 density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On facility tour between 8:30 PM and 1:30 PM on 10/27/2015, it was found in that the facility was storing in corridor near room 234 multiple mobile solid linen and trash container that are greater than 32 gallons in aggregate in spaces that are greater than 64 square feet (in area) and that are open to the corridors and not in the required hazardous storage areas. This deficient practice was verified by the Maintenance Director	K 075	The soiled linen receptacle will be placed in the soiled utility room and all linen will be bagged in the resident's room, then brought out to the soiled utility room for disposal in the soiled linen receptacle. This has the potential to affect all residents, but none have shown any ill effects. Signs will be made and posted on equipment indicating soiled linen and disposal receptacles. They will also be posted on the locked soiled utility door for location and deposit. Education will be conducted with nursing staff by the DON, Maintenance Director, and/or designee by December 8, 2015. Future training will be through orientation for all new hires, and annually for all employees through annual in-service trainings.	

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K 075	Continued From page 6	K 075	Audits will be conducted on a random basis 2x per week for 4 weeks, then 1x per week for 4 weeks. It is the responsibility of the DON, Maintenance Director, and/or designee to ensure compliance. Audits will be reviewed at the monthly QAA meetings x 3 months.	

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	245581	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**10/27/2015**

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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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 11/24/2015

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 _____	**10/27/2015**

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

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K 000	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 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) are MET.	K 000		