Electronically delivered
November 30, 2021

Administrator
Fair Oaks Nursing & Rehab Llc
201 Shady Lane Drive
Wadena, MN 56482

RE: CCN: 245581
Cycle Start Date: November 23, 2021

Dear Administrator:

On November 23, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 February 23, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by May 23, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	C 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS NURSING & REHAB LLC	**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 On 11/22/21, to 11/23/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5581060C (MN67578), with a deficiency cited at F677. H5581062C (MN66275), with a deficiency cited at F677. The following complaint was found to be SUBSTANTIATED: H5581061C (MN67227, MN67245), however NO deficiencies were cited due to actions implemented by the facility prior to survey. AND The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited. H5581058C (MN77378), with a deficiency cited at F609. The following complaints were found to be UNSUBSTANTIATED: H5581057C (MN78013) H5581059C (MN74418) H5581063C (MN62542) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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

Electronically Signed | 12/07/2021

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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F 000	Continued From page 1 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		12/17/21

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F 609	Continued From page 2 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 ensure incidents of potential abuse were immediately reported to the State Agency (SA), no later than 2 hours after knowledge of the allegation of abuse, for 1 of 4 residents (R2) reviewed for allegations of abuse. Findings include: R2's quarterly Minimum Data Set (MDS) dated 10/06/21, identified R2 had diagnoses which included: anxiety disorder, depression and chronic obstructive pulmonary disease (COPD). The MDS identified R2 had intact cognition and was independent with activities of daily living (ADL's) for transfers; required supervision for bed mobility and toileting and required extensive assistance with dressing. The MDS indicated R2 had no behaviors. R2's current care plan revised 7/6/21, revealed R2 was alert, oriented, a vulnerable adult and was at potential risk for abuse from others. The care plan identified R2 was at increased risk for confrontation with other residents and staff and she preferred no male or African American caregivers. R2's care plan revealed R2 was to be encouraged to verbalize her feelings. The facility SA report dated 10/5/21, at 10:29 a.m. identified R2 reported NA-A entered her room sometime last week and stated, "Sometimes I think you can be a complaining bitch". R2 was unable to provide a specific date or time the incident occurred however, shared the delay to	F 609	R2 allegation was reported to the state agency and investigation completed by the facility. Allegation was not substantiated. Residents have the potential to be affected if allegations are not reported within the specified timeline. Grievances have been reviewed for the past month to ensure appropriate follow-up and reporting per policy. VA reports have been reviewed for the past month to ensure allegations were reported in a timely manner. Any allegations or grievances found out of compliance facility staff will follow up with resident to ensure no negative outcome has occurred. Social Service Director has received education. Staff have been educated on the reporting requirements of suspected abuse and neglect. Audits of grievances and allegations will be completed weekly x 4 weeks to ensure timely reporting of allegations, as applicable to state and federal regulations, are reported immediately to the administrator and to the state agency within specified timeline. Audit results will be reviewed at QAPI to determine continued frequency of audits. Administrator is responsible for compliance.	

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F 609	Continued From page 3	F 609		

report the incident was due to feelings of intimidation. The facility SA report detailed the initial reporter was the administrator who was made aware of the verbal abuse allegation on 10/5/2021, at 9:05 a.m.

The facility SA report further identified the allegation of verbal abuse was first reported to the social worker on 10/4/21, at 4 p.m. The SA report was submitted by the facility on 10/5/2021, at 10:29 a.m., eighteen hours and 29 minutes after the incident was first reported.

R2's medical record lacked an internal incident report.

On 11/23/21, at 2:15 p.m. during an interview the social service director (SSD), confirmed she had been made aware of R2's verbal abuse allegation on 10/4/2021, at 4:00 p.m. The SSD verified she did not report the allegation on 10/4/21, as R2 requested to not have it reported. On 10/5/21, at 8:45 a.m. R2 returned to the SSD office and requested to have the verbal abuse allegation reported. SSD confirmed on 10/5/21, at 9:05 a.m. the administrator was notified of R2's verbal abuse allegation.

On 11/23/21, at 11:40 a.m. during an interview the administrator confirmed she was notified of R2's verbal abuse allegation on 10/5/2021, at 9:05 a.m. and submitted the report to the SA on 10/5/21, at 10:29 a.m. The administrator stated the social worker had been provided with verbal education related to the mandated reporting requirements.

The facility policy titled Vulnerable Adult Abuse and Neglect Prevention revised 11/17/20,

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F 609	Continued From page 4 identified all allegations and/or suspicions of abuse were to be reported to the administrator or designee immediately and the facility must report to the SA immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the suspicion do not result in serious bodily injury.	F 609		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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 assistance with facial hair removal and hair care for 1 of 3 residents (R3) who required assistance with personal hygiene. Findings include: R3's significant change of status assessment (SCSA) Minimum Data Set (MDS) dated 10/25/21, identified R3 had diagnoses which included: a fracture, depression, psychotic disorder and arthritis. The MDS identified R3 had severe cognitive impairment and required assistance with activities of daily living (ADL's) of dressing, personal hygiene and bathing. The MDS revealed R3 had no rejection of cares during the assessment period. R3's care plan revised 10/25/21, revealed R3 had	F 677	R3 received hair care and trimming of facial hair. Residents□ dependent on staff for grooming have potential to be affected if assistance is not provided. Residents in the facility have been observed to ensure they have received appropriate grooming completed including trimmed facial hair and combed hair. Nursing staff have been educated on providing grooming assistance to dependent residents. Grooming audits including observation of facial hair and hair will be completed weekly x 4 weeks to ensure residents are receiving assistance with grooming. Audits will be reviewed at QAPI to determine need to continue. DON/Designee will be responsible.	12/17/21

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F 677	Continued From page 5	F 677		

impaired cognition, required extensive assistance with dressing, bathing and personal hygiene. R3's care plan lacked direction for R3's facial hair removal.

R3's nursing assistant care guide dated 11/23/21, revealed R3 required assist of one with bathing, dressing and personal hygiene.

On 11/22/21, at 10:10 a.m. during an observation, R3 was seated in a wheelchair in her room, faced the television and held a purse in her lap. R3 had white hair approximately ten centimeters in length, the back of R3's hair was matted to her scalp and stuck straight up on all sides of the crown of her head. R3 had several dozen thick white hairs on her chin, lower jaw and around her lip line approximately six (6) to eight (8) millimeters (mm) in length. R3 rummaged through her purse as she conversed with herself.

-at 10:31 a.m. R3 was observed to remain seated in a wheelchair in her room, looked at the television when, nursing assistant (NA)-B entered her room, she brought her two pre-packed snack bars, placed them on an over the bed table and stood within two feet of R1's face and told R1 she had brought her some snacks. NA-B then left R1's room and was not observed to offer R1 assistance with grooming.

-at 10:52 a.m. R1 was observed to remain seated in a wheelchair in her room, her hair continued to stick up on all sides of her matted crown and she continued to have several dozen thick 6-8 mm long, white hairs on her chin, lower jaw and around her lip line. NA-B and licensed practical nurse (LPN)-A entered R1's room and assisted her with toileting using a mechanical sit to stand

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F 677	Continued From page 6 lift and assisted R1 back to her wheelchair. On 11/22/21, at 11:12 a.m. during an interview, NA-B stated R1 required extensive assistance with her ADL's of grooming, bathing and dressing. NA-B stated R1 had impaired cognition and her needs were to be anticipated. She stated she had assisted R1 with morning cares and indicated she had not combed R1's hair or removed her facial hair and had planned to return to assist R1 with grooming later that day, however had not been able to. NA-B indicated she had not worked in a few days, felt R1's facial hair had not been shaved for a few days based on the length and felt her hair had not been combed for the same length of time. NA-B then obtained a razor and proceeded to shave R1's facial hair and indicated she would attempt to brush the matt out of R1's hair. On 11/22/21, at 11:25 a.m. during an interview, LPN-A indicated R1 required extensive assistance with all of her ADL's of dressing, grooming, bathing and all of her mobility. LPN-A indicated R1 had severe cognitive impairment and was not always able to verbalize her needs or wishes. LPN-A stated R1 should have been assisted with shaving at least weekly, and as needed. She indicated R1's hair should have been brushed daily and felt R1 had not been shaved or had her hair brushed for the last few days. On 11/23/21, at 11:25 a.m. R1 was observed seated in her room, in a wheelchair, faced the window, she held a blanket in her lap. R1's hair was sticking up on all sides of her crown and continued to have her hair matted to the back of her head.	F 677		

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F 677	Continued From page 7 On 11/23/21, at 11:35 a.m. during an interview, LPN-B stated R1 required extensive assistance with all of her cares and her needs were to be anticipated. LPN-B indicated R1 was compliant with cares, usually had her facial hair removed weekly with her bath and should have her hair brushed daily. On 11/23/21, at 11:45 a.m. during an interview, NA-C indicated R1 required extensive assistance with all of her cares besides eating and was not able to routinely verbalize her needs or wishes. NA-C stated she had assisted R1 with morning cares and was not able to fully brush out the matting on the back of R1's head. She indicated R1 would have her hair washed with her bath and would use conditioner to get the matting out. On 11/23/21, at 11:53 a.m. during an interview the director of nursing (DON) stated R1 required extensive assistance with ADL's and she would expect R1 to be assisted with shaving at least weekly with her bath, as needed and R1's hair should have been brushed daily. A facility policy titled Activities of Daily Living dated 3/15/21, identified it was the policy of the facility to provide the necessary care and services to maintain activities of daily living and provided care and services to include bathing, dressing, grooming and oral cares.	F 677		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 30, 2021

Administrator
Fair Oaks Nursing & Rehab Llc
201 Shady Lane Drive
Wadena, MN 56482

Re: State Nursing Home Licensing Orders
Event ID: 9VQ311

Dear Administrator:

The above facility was surveyed on November 22, 2021 through November 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	C 11/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/22/21, to 11/23/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5581060C (MN67578),with a licensing order issued at 0915. H5581062C (MN66275), with a licensing order issued at 0915. The following complaint was found to be SUBSTANTIATED: H5581061C (MN67227, MN67245), however NO licensing orders were cited due to actions implemented by the facility prior to survey. The following complaint was found to be UNSUBSTANTIATED: H5581058C (MN77378), however, a related licensing order was issued at 1980. AND The following complaints were found to be UNSUBSTANTIATED: H5581057C (MN78013) H5581059C (MN74418) H5581063C (MN62542) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings	2 000		

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2 000	Continued From page 2 are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the	2 915		12/17/21

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2 915	Continued From page 3 resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with facial hair removal and hair care for 1 of 3 residents (R3) who required assistance with personal hygiene. Findings include: R3's significant change of status assessment (SCSA) Minimum Data Set (MDS) dated 10/25/21, identified R3 had diagnoses which included: a fracture, depression, psychotic disorder and arthritis. The MDS identified R3 had severe cognitive impairment and required assistance with activities of daily living (ADL's) of dressing, personal hygiene and bathing. The MDS revealed R3 had no rejection of cares during the assessment period. R3's care plan revised 10/25/21, revealed R3 had impaired cognition, required extensive assistance with dressing, bathing and personal hygiene. R3's care plan lacked direction for R3's facial hair removal. R3's nursing assistant care guide dated 11/23/21,	2 915	Acknowledged	

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2 915	Continued From page 4 revealed R3 required assist of one with bathing, dressing and personal hygiene. On 11/22/21, at 10:10 a.m. during an observation, R3 was seated in a wheelchair in her room, faced the television and held a purse in her lap. R3 had white hair approximately ten centimeters in length, the back of R3's hair was matted to her scalp and stuck straight up on all sides of the crown of her head. R3 had several dozen thick white hairs on her chin, lower jaw and around her lip line approximately six (6) to eight (8) millimeters (mm) in length. R3 rummaged through her purse as she conversed with herself. -at 10:31 a.m. R3 was observed to remain seated in a wheelchair in her room, looked at the television when, nursing assistant (NA)-B entered her room, she brought her two pre-packed snack bars, placed them on an over the bed table and stood within two feet of R1's face and told R1 she had brought her some snacks. NA-B then left R1's room and was not observed to offer R1 assistance with grooming. -at 10:52 a.m. R1 was observed to remain seated in a wheelchair in her room, her hair continued to stick up on all sides of her matted crown and she continued to have several dozen thick 6-8 mm long, white hairs on her chin, lower jaw and around her lip line. NA-B and licensed practical nurse (LPN)-A entered R1's room and assisted her with toileting using a mechanical sit to stand lift and assisted R1 back to her wheelchair. On 11/22/21, at 11:12 a.m. during an interview, NA-B stated R1 required extensive assistance with her ADL's of grooming, bathing and dressing. NA-B stated R1 had impaired cognition and her needs were to be anticipated. She stated she had	2 915		

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2 915	Continued From page 5 assisted R1 with morning cares and indicated she had not combed R1's hair or removed her facial hair and had planned to return to assist R1 with grooming later that day, however had not been able to. NA-B indicated she had not worked in a few days, felt R1's facial hair had not been shaved for a few days based on the length and felt her hair had not been combed for the same length of time. NA-B then obtained a razor and proceeded to shave R1's facial hair and indicated she would attempt to brush the matt out of R1's hair. On 11/22/21, at 11:25 a.m. during an interview, LPN-A indicated R1 required extensive assistance with all of her ADL's of dressing, grooming, bathing and all of her mobility. LPN-A indicated R1 had severe cognitive impairment and was not always able to verbalize her needs or wishes. LPN-A stated R1 should have been assisted with shaving at least weekly, and as needed. She indicated R1's hair should have been brushed daily and felt R1 had not been shaved or had her hair brushed for the last few days. On 11/23/21, at 11:25 a.m. R1 was observed seated in her room, in a wheelchair, faced the window, she held a blanket in her lap. R1's hair was sticking up on all sides of her crown and continued to have her hair matted to the back of her head. On 11/23/21, at 11:35 a.m. during an interview, LPN-B stated R1 required extensive assistance with all of her cares and her needs were to be anticipated. LPN-B indicated R1 was compliant with cares, usually had her facial hair removed weekly with her bath and should have her hair brushed daily.	2 915		

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2 915	Continued From page 6 On 11/23/21, at 11:45 a.m. during an interview, NA-C indicated R1 required extensive assistance with all of her cares besides eating and was not able to routinely verbalize her needs or wishes. NA-C stated she had assisted R1 with morning cares and was not able to fully brush out the matting on the back of R1's head. She indicated R1 would have her hair washed with her bath and would use conditioner to get the matting out. On 11/23/21, at 11:53 a.m. during an interview the director of nursing (DON) stated R1 required extensive assistance with ADL's and she would expect R1 to be assisted with shaving at least weekly with her bath, as needed and R1's hair should have been brushed daily. A facility policy titled Activities of Daily Living dated 3/15/21, identified it was the policy of the facility to provide the necessary care and services to maintain activities of daily living and provided care and services to include bathing, dressing, grooming and oral cares. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults	21980		12/17/21

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21980	Continued From page 7 Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to	21980		

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21980	Continued From page 8 the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse were immediately reported to the State Agency (SA), no later than 2 hours after knowledge of the allegation of abuse, for 1 of 4 residents (R2) reviewed for allegations of abuse. Findings include: R2's quarterly Minimum Data Set (MDS) dated 10/06/21, identified R2 had diagnoses which included: anxiety disorder, depression and chronic obstructive pulmonary disease (COPD). The MDS identified R2 had intact cognition and was independent with activities of daily living (ADL's) for transfers; required supervision for bed mobility and toileting and required extensive assistance with dressing. The MDS indicated R2 had no behaviors. R2's current care plan revised 7/6/21, revealed R2 was alert, oriented, a vulnerable adult and was at potential risk for abuse from others. The care plan identified R2 was at increased risk for confrontation with other residents and staff and she preferred no male or African American caregivers. R2's care plan revealed R2 was to be	21980	Acknowledged	

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21980	Continued From page 9 encouraged to verbalize her feelings. The facility SA report dated 10/5/21, at 10:29 a.m. identified R2 reported NA-A entered her room sometime last week and stated, "Sometimes I think you can be a complaining bitch". R2 was unable to provide a specific date or time the incident occurred however, shared the delay to report the incident was due to feelings of intimidation. The facility SA report detailed the initial reporter was the administrator who was made aware of the verbal abuse allegation on 10/5/2021, at 9:05 a.m. The facility SA report further identified the allegation of verbal abuse was first reported to the social worker on 10/4/21, at 4 p.m. The SA report was submitted by the facility on 10/5/2021, at 10:29 a.m., eighteen hours and 29 minutes after the incident was first reported. R2's medical record lacked an internal incident report. On 11/23/21, at 2:15 p.m. during an interview the social service director (SSD), confirmed she had been made aware of R2's verbal abuse allegation on 10/4/2021, at 4:00 p.m. The SSD verified she did not report the allegation on 10/4/21, as R2 requested to not have it reported. On 10/5/21, at 8:45 a.m. R2 returned to the SSD office and requested to have the verbal abuse allegation reported. SSD confirmed on 10/5/21, at 9:05 a.m. the administrator was notified of R2's verbal abuse allegation. On 11/23/21, at 11:40 a.m. during an interview the administrator confirmed she was notified of R2's verbal abuse allegation on 10/5/2021, at 9:05 a.m. and submitted the report to the SA on	21980		

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21980	Continued From page 10 10/5/21, at 10:29 a.m. The administrator stated the social worker had been provided with verbal education related to the mandated reporting requirements. The facility policy titled Vulnerable Adult Abuse and Neglect Prevention revised 11/17/20, identified all allegations and/or suspicions of abuse were to be reported to the administrator or designee immediately and the facility must report to the SA immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the suspicion do not result in serious bodily injury. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse, neglect and misappropriation of property were within appropriate time frames for reporting. The facility should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 14 DAYS	21980		