



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 21, 2023

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

RE: CCN: 245581
Cycle Start Date: July 28, 2023

Dear Administrator:

On August 31, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 21, 2023

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

Re: Reinspection Results
Event ID: XJVC12

Dear Administrator:

On August 31, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 28, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2023

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

RE: CCN: 245581
Cycle Start Date: July 28, 2023

Dear Administrator:

On July 28, 2023, a survey was completed at your facility by the Minnesota Department of Health 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Fair Oaks Nursing & Rehab LLC

August 15, 2023

Page 2

- 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 October 28, 2023 (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 January 28, 2024 (six months after

Fair Oaks Nursing & Rehab LLC

August 15, 2023

Page 3

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

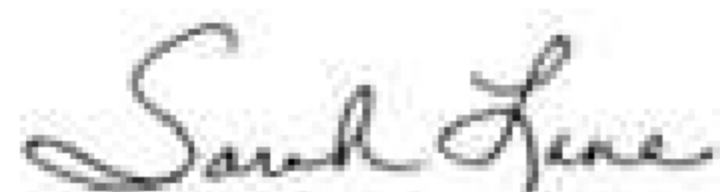
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: XJVC11

Dear Administrator:

The above facility was surveyed on July 25, 2023 through July 28, 2023 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.

Fair Oaks Nursing & Rehab LLC

August 15, 2023

Page 2

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.

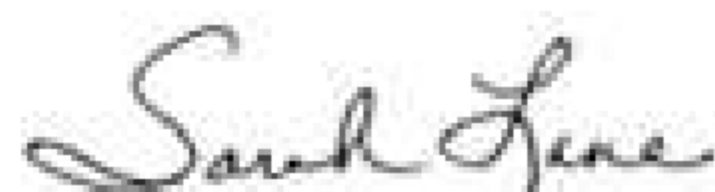
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 7/25/23, to 7/28/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed</p>	2 000		
-------	--	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/25/23
---	-------	------------------------------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 1</p> <p>these orders and identify the date when they will be completed.</p> <p>The following complaints were reviewed.</p> <p>H55813922C (MN00095406)</p> <p>H55814004C (MN00095408)</p> <p>H55814002C (MN00095174) with a licensing orders issued at 800 and 1805</p> <p>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 are the Suggested Method of Correction and Time Period for Correction.</p> <p>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</p>	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

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

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

2 000	Continued From page 2 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		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide sufficient staffing to meet the care needs of the residents in a timely manner for 8 of 10 residents (R1, R2, R4, R5, R6, R7, R8, R11) reviewed for staffing. Findings include: R1's five-day assessment Minimum Data Set	2 800	corrected	8/28/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 3</p> <p>(MDS) dated 6/27/23, identified moderately impaired cognition with no behaviors. R1 required extensive assistance of for bed mobility, transfers, personal hygiene, toileting, and dressing and independent in wheelchair for locomotion. R1 was always continent of bladder and occasionally incontinent of bowel. R1 received diuretics (increased production of urine) seven days out of seven days of the look back period.</p> <p>R1's care plan dated 7/28/23, identified R1 required extensive assist of two staff with the sit to stand lift for transfers.</p> <p>R1's Kardex dated 7/28/23, identified R1 required extensive assistance of one with toilet use and extensive assistance of two with the sit to stand lift. Staff were instructed to turn and reposition R1 every two hours.</p> <p>During an observation on 7/28/23 at 12:47 p.m. R1 wheeled himself around in wheelchair approached surveyor in the hallway by the entry way. R1 stated tried to find someone to help him to the bathroom, but seemed liked when he looked, they all disappeared. R1 then approached an unidentified staff who was pushing a mechanical lift machine down the hallway. R1 asked the staff if he could get help going to the bathroom. The staff stated my partner was on break and there were only two staff on the floor working right now so R1 would have to wait at least another 20 minutes before he could be helped and walked away. R1 pushed himself over to the television room and said out loud, "geez hope I can wait that long."</p> <p>During an interview on 7/15/23 at 2:15 p.m. R1 stated they were a morning person and wanted to</p>	2 800		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 4</p> <p>be up by 6:30 a.m., usually placed call light on but the staff were slow to answer, and sometimes had to wait up to 20 minutes in the morning to get up. R1 verified staff came in, shut call light off, said they would come back, and had taken a while before they returned. R1 also stated there were times when it had taken much longer to get help, up to an hour, and usually fell asleep waiting for them to help.</p> <p>R2's significant change MDS dated 6/9/23 identified intact cognition and no behaviors. R2 had diagnoses of anxiety and congestive heart failure (CHF). R2 required extensive assistance of one for bed mobility, personal hygiene, and dressing and extensive assistance of two for transfers and toilet use. R1 was frequently incontinent of bowel and bladder. R1 received diuretics (increased production of urine) seven out of seven days during the look back period.</p> <p>R2's care plan date 7/28/23, identified staff were directed to reposition resident at least every two hours per tolerance and schedule.</p> <p>R2's Kardex dated 7/28/23, identified R2 required assist of one staff for toileting and incontinent of bowel and bladder at times.</p> <p>R2's bladder assessment completed on 7/18/23, identified R2 always incontinent of urine and voiding pattern after breakfast, lunch, supper, and at bedtime.</p> <p>R2's bladder urinary continence record from 7/20/23, through 7/25/23, identified:</p> <p>-7/20/23 incontinent 2:27 a.m., 10:00 a.m., and 3:03 p.m. -7/21/23 incontinent 12:11 a.m. and 5:46 p.m.</p>	2 800		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 5</p> <p>-7/22/23 incontinent 1:39 p.m., 1:59 p.m., and 2:46 p.m. -7/23/23 continent 5:31 a.m. and incontinent 10:22 a.m. and 2:37 p.m. -7/24/23 incontinent 12:04 a.m., 9:30 a.m., and 9:59 p.m. -7/25/23 incontinent 1:43 a.m., 9:28 a.m., and 5:42 p.m.</p> <p>During an interview on 7/25/23 at 3:15 p.m. R2 stated staff came into their room, turned off call light and told me they would be right back, and no one came back. R2 indicted she then turned the call light on again 30 minutes later and staff repeated the same process. R2 verified it would take up to three hours to put her back to bed or get her up at times. R2 stated she knew staff were busy but counted on their word when they told her they would be right back and after a while they need to come back and take care of those they forgot. R2 also stated she felt like she had been forgotten and indicated she had complained to nurses, NA's and the social worker. R2 stated she hesitated to put on the call light when staff were so busy, staff made her feel like she made it harder on them when she used the call light, and she became frustrated. R2 stated felt tension in the air when staff started quitting and the remaining staff had told her they were required to pick up the slack. R2 identified they could do better but hard to do when short staffed frequently. R2 indicted the long wait times seemed to be worse in the afternoons between supper and 10:00 p.m., staff ran ragged and complained about how they were over worked. R2 stated once she was back in bed it became even harder to get staff to answer the call light to get help.</p> <p>During an observation on 7/26/23 at 8:30 a.m. R2</p>	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 6</p> <p>laid in bed and breakfast tray located on a bedside table, remained untouched and unreachable. At 8:56 a.m. dietary staff entered R2's room and attempted to removed breakfast tray from bedside table. R2 stated "No do not take that I have not eaten yet, the table was too far away". Dietary exited the room and R2's breakfast tray remained unreachable. At 8:57 a.m. R2 waved an unidentified staff over to her and requested the table be pulled closer to her so she could eat her breakfast. Staff assisted R2.</p> <p>R4's quarterly MDS dated 6/27/23, identified intact cognition and no behaviors. R4 required extensive assistance for bed mobility, transfers, personal hygiene, toileting, and dressing and total dependence for locomotion. R4 was always incontinent of bowel and bladder, high risk for pressure ulcers, and turning/repositioning program.</p> <p>R4's care plan dated 7/28/23, identified R4 had alterations in elimination related to a history of cerebral infarction (stroke), hemiplegia (weakness on one side of the body), spinal stenosis (narrowing), and incontinent of bladder at times. R4's care plan directed staff to provide incontinence care due to bowel and bladder incontinence to have kept R4 clean, dry, and odor free daily through staff assistance and interventions. R4 received diuretics (increased production of urine) seven out of seven days.</p> <p>R4's Kardex dated 7/28/23, identified R4 required assistance with turning every two hours and as needed, check and change and bedpan offered due to bowel and bladder incontinence. R4 required assist of two staff and a total lift to transfer.</p>	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 7</p> <p>R4's bladder assessment dated 6/25/23, identified conditions impacted urinary continence included cerebral vascular accident, obesity, pain, and diabetes. R4 had functional incontinence (related to inability to toilet due to cognitive or physical functioning). R4's perception of the need to void was absent and required physical assistance in toileting.</p> <p>R4's bladder urinary continence record from 7/20/23, through 7/25/23, identified:</p> <p>-7/20/23, incontinent 9:52 p.m. and 5:15 p.m.</p> <p>-7/21/23, incontinent 12:06 a.m., 12:31 p.m., and 8:55 p.m.</p> <p>-7/22/23, incontinent 12:56 a.m., 1:59 p.m., and 2:38 p.m.</p> <p>-7/23/23, incontinent 5:25 a.m., 12:57 p.m., and 2:50 p.m.</p> <p>-7/24/23, incontinent 12:02 a.m., 9:32 a.m., and 9:52 p.m.</p> <p>-7/25/23, incontinent 1:38 a.m., 9:30 a.m., and 5:10 p.m.</p> <p>R4's bowel assessment dated 6/25/23, identified always incontinent of bowel.</p> <p>During an interview on 7/25/23 at 10:35 a.m. R4 laid in bed and alleged she had been laying in urine and stool for at least four hours now (See R4's bladder urinary continence record). R4 verified staff had not been checked and changed her since around 2:00 a.m. and that happened almost every day. R4 indicated she required assistance with cares and was unable to walk. R4</p>	2 800		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 8</p> <p>stated she would like to have received morning cares earlier today but found it difficult to get assistance from staff. R4 stated the lack of staff assistance had been going on for about four months now. R4 indicated the bed sheets were generally changed every day due to wet sheets from urine, she laid there too long. R4 stated on Saturdays she hollered for staff and reminded them she needed her shower otherwise was forgotten. R4 indicated she had placed her call light on, waited up to one hour, staff came in, shut off call light, and told R4 they would be back, and did not return. R4 stated it "broke her heart" she could not get the help she needed. R4 stated she wanted to be up out of bed and in her chair daily, and staff informed her they did not have time to get her up, so she stayed in bed.</p> <p>During an observation on 7/25/23 at 10:55 a.m. R4 placed her call light on and NA-C answered in at 11:09 a.m. (14 minutes). R4 asked to be changed and NA-C stated we needed to change your sheets also, required another staff to assist, and exited the room at 11:10 a.m.</p> <p>During an observation and interview on 7/25/23 at 11:45 a.m., (35 minutes later) NA-C and NA-D entered R4's room and applied gloves. NA-D and NA-C completed cares for R4. NA-D confirmed the brief had stool smeared on it and 50 percent saturated with urine. ND-C removed the sheets from R4's bed and placed them in a clear bag.</p> <p>R5's Significant change MDS dated 7/10/23, identified intact cognition and no behaviors. R5 required extensive assistance with personal hygiene, limited assistance with toileting, and supervision with transfers. R5 always continent of bowel and bladder. R5's diagnoses included anxiety disorder, depression, and schizophrenia.</p>	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 9</p> <p>R5 received a diuretic seven out of seven days during look back period.</p> <p>R5's care plan dated 7/28/23, identified R5 had a ADL self-care deficit due to rheumatoid arthritis, diabetes mellitus, physical deconditioning, paranoid schizophrenia, morbid obesity, and poor eye sight. Staff were directed to assist R5 with bathing, dressing, toilet use, bed mobility, transfers assist of one in the morning and two assist after 8:00 p.m., and approach R5 warmly, positively, empathy, and understanding to bolster self-coping skills.</p> <p>R5's Kardex dated 7/28/23, identified R5 required assist of one to use toilet and complete personal hygiene.</p> <p>R5's bowel continence floor sheet dated 7/28/23 identified:</p> <p>-7/16/23 at 1:59 p.m. incontinent of bowel</p> <p>-7/26/23 at 9:31 p.m. incontinent of bowel</p> <p>During an interview and observation on 7/26/23 at 9:17 a.m., R5 sat in wheelchair with only a shirt and brief on and no shoes or slippers. R5 stated she had placed her call light on and had been waiting for assistance to wipe up the floor where she spilled her breakfast juice on her lap and then onto the floor. R5 stated staff took up to one hour to respond to the call light. R4 verified it had been hard to get help with anything especially on the evening and night shift, which seemed like staff did not want to come and answer it. R5 stated she had not complained about this, as she did not want to get any staff in trouble, but it made her mad and frustrated. R5 indicated she had a hard time getting fresh water, had waited up to 3</p>	2 800		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 10</p> <p>hours, and could pretty much do everything else for herself. At 9:37 a.m. (20 minutes later) NA-A knocked on door, entered the room and asked what she needed. R5 stated her wet pants needed to be picked up and NA-A stated, "oh is that all you needed?" NA-A cleaned up the floor with a towel and exited the room. R5 stated she tried to do as much for herself as possible but was unable to complete her own pericare and it was hard to get a staff to help. R5 added, staff have told her evening cares would be completed at 9:00 p.m. but staff do not come in until 10:00 p.m. Lastly, R5 added, her anxiety level increase when call light response times take so long and this affects her mental health.</p> <p>R6's significant change MDS date 5/15/23, identified intact cognition and no behaviors. R6 required extensive assistance with bed mobility, dressing, personal hygiene, toileting, and total dependence on staff for transfers. R6 frequently incontinent of bladder and occasionally incontinent of bowel. R6's diagnoses included anxiety and manic depression.</p> <p>R6's care plan dated 7/28/23, identified R6 had limited physical mobility related to muscle weakness, deformities of the foot, essential tremors, morbid obesity, chronic pain, fibromyalgia, and contractures of the left hand. R6's care plan directed staff to transfer R6 full body lift and assistance of two staff and routinely turn and reposition at least every two hours.</p> <p>R6's Kardex dated 7/28/23, identified, R6 needed encouragement to off load and/or change positions at least every 2 hours and incontinent of bladder at times.</p> <p>During observation on 7/25/23 at 12:40 p.m. R6's</p>	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 11</p> <p>call light was noted to be on. Activities staff walked down hallway past R6's room, entered a neighbor's room, and did not answer the call light.</p> <p>During an interview on 7/25/23 at 12:45 p.m. R6 stated she placed call light on a bit ago, NA-A turned call light off, informed R6 would look for another staff to help her. R6 stated she had waited up to approximately 45 minutes at times to receive assistance from staff. R6 stated she had just placed call light on again and waited for assistance. R6 confirmed she had urine accidents, it had been a while, she tried to hold it until staff came to help her. R6 stated staff got upset when she would ask for small things usually during the evening and nighttime shifts. R6 stated she had been told by staff they have other people to take care of and to get to the point, and were in a rush to leave her room. R6 stated she understood they were busy but it only took a few minutes to help her and made her feel like she was a burden to them.</p> <p>During an observation on 7/25/23 at 12:55 p.m. NA-A and NA-D entered R6's room, turned call light off and assisted R6 with toileting.</p> <p>R6's call light log on 7/25/23, identified:</p> <ul style="list-style-type: none"> -call light was activated at 12:27 p.m. and was responded to 2 minutes 56 seconds after it was activated. -call light was activated at 12:38 p.m. and was responded to 14 minutes 41 seconds after it was activated. -call light was activated at 12:59 p.m. and was responded to 10 minutes 23 seconds after it was activated. 	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 800	<p>Continued From page 12</p> <p>R6 received assistance with toileting almost 30 minutes after she had placed the call light on initially.</p> <p>R7's Admission MDS dated 7/12/23, identified intact cognition and no behaviors. R7 required extensive assistance with bed mobility, dressing, toilet use, personal hygiene and total dependence with transfers. R7 was frequently incontinent of bowel and bladder with a history of urinary tract infections.</p> <p>R7's care plan dated 7/18/23, identified R7 had an ADL self-care deficit related to osteoporosis pain, muscle spasms, weakness, and deconditioning. Staff were instructed to provide assist of two with sit to stand lift, keep pressure off of left lower heel/extremity, and may use bedside commode for toileting.</p> <p>Interview on 7/26/23 at 1:20 p.m., R7 laid in bed on her back. R7 stated the call light wait times get to be long in the morning because they are short staffed. R7 stated two weeks ago, she placed her call light on early in the morning around just after 9:00 a.m. and took staff over 20 minutes later staff came in, turned off call light, informed her they would be right back, and staff returned much later. R7 stated she laid in bed from 7:00 a.m. to 10:30 a.m. incontinent of urine, and wanted to be up by at least 9:00 a.m. R7 stated she has to wait up to two hours to get laid down and staff tell me they will help, but do not come back. R7 stated she felt so helpless and unable to get help when needed.</p> <p>On 7/12/23, R7's call light was activated at 9:12 a.m. and was responded to 25 minutes 33 seconds after it was activated.</p>	2 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 13</p> <p>Review of R7's urinary continence dated 7/12/23 at 10:37 a.m. R7 was incontinent of urine.</p> <p>R8's Significant change MDS dated 6/27/23, identified intact cognition and no behaviors. R8 required extensive assistance with bed mobility, dressing, and toilet use and limited assistance with personal hygiene, and transfers. R8 was occasionally incontinent of bladder and always continent of bowel. R7 received a diuretic 7 out of 7 days during the look back period.</p> <p>R8's care plan dated 7/28/23, identified an ADL self-care deficit related to chronic right shoulder pain and obesity. Staff were instructed to provide assistance with peri cares to help avoid further urinary tract infections and check and change as needed due to incontinence.</p> <p>R8's Kardex identified required assistance of one for bathing and assistance with lower body cleansing.</p> <p>During an interview on 7/26/23 at 12:51 p.m. R8 stated they are short staffed quite often, especially on weekends. R8 stated this past Saturday on 7/22/23, staff called in sick and there was (verified by schedule)only one staff on the floor for about two hours. R8 indicated she did had not received her scheduled shower that day. R8 stated last evening on 7/25/23, NA-A arrived in her room and instructed her to turn the call light off. R8 stated she asked NA-A for a gown and assistance with evening cares, NA-A left the room and did not return. R8 stated she placed call light on again that evening but no one came so R8 turned off light, and fell asleep in her clothing. R8 stated she does not feel the facility has enough staff to meet our needs. R8 stated earlier this</p>	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 14</p> <p>month, used call light early in the morning, and waited up to over an hour for assistance. R8 also stated on 7/26/23, she had been yelled at by an NA at 6:30 a.m. when she placed her call light on before 6:30 a.m. and was told to not to use the call light prior to 6:30 a.m., staff were in report. R8 stated she waited until closer to 8:00 a.m. placed the call light on again and received assistance. R8 stated had not told any one because it would not do any good. R8 stated she would have told the social worker but had previously talked to her, and had not received much help. R8 indicated she does usually attended the resident counsel meeting, but was in too much pain to attend the last one. R8 had brought up concerns during a previous resident counsel meeting and nothing was really resolved.</p> <p>Review of facility staff schedule day shift on 7/22/23 identified: day shift 6:00 a.m. to 2:30 p.m. one float NA and 7:00 a.m. to 2:30 p.m. one NA, and one nurse. (short NA from 6:00 a.m. to 7:00 a.m. and 9:30 a.m. to 10:30 a.m. and short two NA's from 10:30 a.m. to 2:30 p.m.) one nurse 6:00 a.m. to 7:15 a.m. two nurses from 7:15 a.m. to 8:30 a.m., three nurses 8:30 a.m. to 10:30 a.m., two nurses 10:30 a.m. to 2:30 p.m. (short nurse from 6:00 a.m. to 7:15 a.m.)</p> <p>Review of the call light times for R8 revealed on 7/26/23, her call light was activated at 6:27 a.m. and not again until 7:50 a.m.:</p> <p>On 7/26/23, the call light was activated at 6:27 a.m. and was responded to 13 minutes 3 seconds after it was activated.</p> <p>On 7/26/23, the call light was activated AT 7:50 a.m. and was responded to 41 seconds after it</p>	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 15</p> <p>was activated.</p> <p>R8's shower/bathing record indicated no shower/bath was documented as completed on 7/22/23, as indicated by R8 in interview.</p> <p>During an interview on 7/26/23 at 2:07 p.m. NA-A stated did not assist R8 with evening cares last night, no recall of answering R8's call light, and R8 did not need help with cares anyway.</p> <p>R11's Significant change MDS dated 7/26/23, identified intact cognition and no behaviors. R11 required extensive assistance for bed mobility, transfers, personal hygiene, toileting, dressing, and locomotion. R11 was occasionally incontinent of bladder and frequently incontinent of bowel with a history of bladder infections.</p> <p>R11's care plan dated 7/28/23, identified R4 had an activities of daily living (ADL) self-care deficit related to contractures of bilateral hands, altered mental status, low back pain, and weakness. R11 required assist of two staff for toilet us. Staff were directed to offer toileting every two hours.</p> <p>R11's Kardex dated 7/28/23, identified R4 required assist of two and EZ stand to transfer and offer toileting every two hours and document refusals.</p> <p>R11's Bladder evaluation dated 7/26/23, identified frequently incontinent due to memory problems, impaired decision making, required physical assistance in toileting, obesity, and diabetes. R4's perception of need to void was diminished.</p> <p>During an interview on 7/26/23 at 1:39 p.m. R11 stated she placed call light on this morning around 8:45 a.m. and it took over 30 minutes for</p>	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 16</p> <p>the staff to respond to it. R11 also stated call light did not seem to work at times with how long she had waited for staff to answer it. R11 stated she required assistance of staff and a stand lift to get up to the commode but had urine and stool accidents consistently because of the long wait times to get help. R11 stated when she had accidents, she did not feel very good about herself and felt embarrassed by it. R11 also stated she placed her call light on at about 1:15 p.m. and it was now 1:45 p.m. and no staff had answered it yet. R11 indicated she tried to hold her urine as long as she could but currently had urinary tract infection and it had become difficult to do so. R11 requested surveyor please let staff know she needed help to the bathroom because she was not sure how much longer she could hold it before she had an accident in her pants.</p> <p>Observation on 7/26/23 at 1:52 p.m. two call lights R6 and R11 had been on since 1:45 p.m. located in the same hallway. NA-A walked down hallway to the room next to R11's room carried clean linen, walked into the neighbor's room, and closed the door. Seven minutes later at 1:55 p.m. NA-A walked out of room, did not answer R6 or R11's call lights, and walked down the hallway to the nurse's station slowly.</p> <p>Observation on 7/26/23 at 1:55 p.m. NA-B walked into R11's room, shut off call light, said she would someone to help her and be back, and exited room. NA-B then walked into R6's room, shut off call light, said the same thing and exited the room. NA-B walked back down the hallway to the nurse's station.</p> <p>Observation on 7/26/23 at 2:01 p.m. NA-G walked down hallway and into R11's room and asked, "you need to go to the bathroom?" R11</p>	2 800		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 17</p> <p>stated, "yes, really bad." NA-G exited the room, waked down the hallway and returned to R11's room at 2:03 p.m. NA-G placed gloves on his hands and informed R11 he had to wait for assistance of another staff. At 2:10 p.m. NA-A entered R11's room, placed gloves on her hands, raised resident up off wheelchair with the sit to stand lift and lowered her onto the commode. NA-G verified R11's brief was dry, gave R11 a call light, exited the room. NA-A and NA-G did not enter R6's room across the hallway and walked the towards the nurse's station.</p> <p>During an interview on 7/25/23 at 3:15 p.m. LPN-A stated staffing was ok on the day and night shifts but evening shift struggled to get all cares and charting completed by the end of their shift. LPN-A confirmed agency staff was filling in tonight due to being short three staff.</p> <p>During an interview on 7/26/23 at 2:34 p.m., NA-E stated they needed more staff to complete all tasks. NA-E stated they had answered one residents call light 15 times already this shift. NA-E indicated there were times when a resident only needed something simple like a television channel changed or asked to be covered up. NA-E confirmed approximately one half of the residents were incontinent of urine by the time they got to them today. NA-E confirmed floor nurses did not answer call lights but trained medication aids (TMA) answered call lights occasionally.</p> <p>During a follow up interview on 7/27/23 at 9:51 a.m., NA-E indicated it was hard to keep up with meeting the resident's basic needs such as toileting and bathes when not enough staff were scheduled. NA-E verified only two staff worked today along with one person training. NA-E also</p>	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 18</p> <p>indicated occasionally a NA floated between the two floors and helped out.</p> <p>During an interview on 7/28/23 at 12:16 p.m. staffing coordinator (SC) stated the facility was staffed according to the census and ratios identified using a computer program. SC indicated the nursing staff schedule was completed one month ahead of time with an average of 10 to 15 NA shifts open a week and 10 nursing shifts were open a week. SC stated she sent out message to all staff and talked to staff individually to fill open shifts. SC stated yesterday on 7/27/23 the facility was short three staff and she had filled them by 8:00 a.m. SC also stated NA's came to her approximately twice a month and informed her there was too much work and too hard of work even when fully staffed. SC stated every other weekend the facility worked short staffed, usually short one NA. SC stated she was unaware as to what the staff cannot get done on their shifts.</p> <p>During an interview on 7/28/23 at 12:56 p.m., assistant director of nursing (ADON) stated they were not aware of any concerns staff regarding staffing and expected the staffing scheduler to have filled the schedule. ADON also stated call lights averaged much less than 10 minutes and audits would have been completed by the social worker. ADON expected staff to prioritize how quickly they answered the call lights and go to the residents first with safety issues. ADON expected staff to take care of the residents and was unable to place a length of time on the expectation regarding answering call lights.</p> <p>During an interview on 7/28/23 at 1:26 p.m. social worker (SW) stated staff and residents had complained about long call light times. SW</p>	2 800		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 19</p> <p>indicated the entire second floor was looked at for one week regarding long call wait times and majority of the call lights were under 15 minutes, some longer, and one was 30 minutes. SW stated these results were shared with DON and ADON and talked about the findings, no notes were taken during this audit or meeting. SW stated they had planned a weekly call light audit for the next three weeks, so the long call light wait times and any trends or specific rooms could be addressed accordingly. SW stated up to a 30 minute wait time would be the maximum time a resident should have to wait for the call light to be answered.</p> <p>During an interview on 7/28/23 at 1:44 p.m. LPN-B stated there were not sufficient staff to meet the needs of resident and provide safe care especially when residents were first admitted. LPN-B stated facility had a high turnover rate of residents with a high acuity. LPN-B stated frequently only two NA's would be scheduled to care for over 30 residents and needs such as toileting and basic cares were not being met.</p> <p>During an interview on 7/28/23 at 1:52 p.m., NA-F stated staffing was an issue, adding two NA's were not enough to care for 33 residents. NA-F indicated they felt rushed through all cares and was unable to take the time needed to care for residents properly. NA-F stated our equipment such as lifts do not work properly, batteries are worn out, and residents are up in the air longer than they should be. NA-F verified approximately 75% of the residents were already incontinent prior to getting assistance from staff due to the length of time it took to get to each one and that should not be happening. NA-F stated most of the time when the facility is short staffed it is due to call ins. NA-F indicated they work three double</p>	2 800		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 20</p> <p>shifts a week due to shortage of staff. NA-F also stated resident wait times are longer than they should be due to staff turning off the call light, informed resident they will return with help, then get busy, and forget to go back to assist them.</p> <p>During an interview on 7/28/23 at 4:30 p.m., director of nursing (DON) stated facility had a staffing coordinator who handled the schedule in general. DON confirmed the assistant director of nursing and herself worked on the floor when needed as well as the health unit coordinator to ensure there was appropriate staffing levels. DON stated two nurse and two to three nursing assistants were more than adequate staff for the main floor and was in fact, better than "normal".</p> <p>FACILITY STAFFING SCHEDULE On 7/28/17, at 12:16 p.m. the facility SC confirmed she developed the facility's staffing pattern and the staffing pattern was based upon the facility census. SC indicated the current staffing pattern for second floor included the following guidelines:</p> <p>Second floor: -Day shift; three NA's and two nurses -Evening shift; two and one half to three NA's and two nurses -Night shift; one and one-half to two NA's and one nurse</p> <p>Also during interview, SC stated the acuity on the night shift has gone up because more residents care needs increased.</p> <p>The facility weekly second floor staffing schedule from 7/17/23 through 7/22/23 identified:</p> <p>7/17/23 day shift 6:00 a.m. to 2:30 p.m. two NA's,</p>	2 800		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 800	<p>Continued From page 21</p> <p>6:00 a.m. to 8:45 a.m. one NA, and two licensed nurses, and one trained medical assistant (TMA). (short NA from 8:45 a.m. to 2:30 p.m.)</p> <p>7/18/23 day shift 6:00 a.m. to 2:30 p.m. one NA, 10:00 a.m. to 2:30 p.m. one NA, 6:00 a.m. to 11:00 a.m. one NA training another new NA, and two nurses and a TMA. (short NA from 11:00 a.m. to 2:30 p.m.)</p> <p>7/18/23 evening shift 2:00 p.m. to 10:30 p.m. one nurse, 2:00 p.m. to 4:00 p.m. one nurse, and 4:00 p.m. to 10:30 p.m. one nurse. (short one nurse)</p> <p>7/19/23 day shift 6:00 a.m. to 2:30 p.m. one NA, 8:00 a.m. to 2:30 p.m. one NA and one in training and two nurses. (short two NA's from 6:00 a.m. to 8:00 a.m. and short one NA from 6:00 a.m. to 2:30 p.m.)</p> <p>7/19/23 evening shift 2:00 p.m. to 10:30 p.m. two NA's and 5:00 p.m. to 8:00 p.m. one NA, and 2:00 p.m. to 10:30 p.m. one nurse, and 2:00 p.m. to 10:30 p.m. one nurse. (short NA from 2:00 p.m. to 5:00 p.m. and 8:00 p.m. to 10:30 p.m.)</p> <p>7/19/23 night shift 10:00 p.m. to 6:30 a.m. one NA and one nurse. (short one NA from 10:00 p.m. to 6:30 a.m.)</p> <p>7/20/23 day shift 6:00 a.m. to 2:30 p.m. three NA's and 6:00 a.m. to 2:30 p.m. two nurses.</p> <p>7/20/23 evening shift 2:00 p.m. to 6:00 p.m. 3 NA's, 6:00 p.m. to 9:00 p.m. 3 NA's and one in training. 9:00 p.m. to 10:30 p.m. one NA and one in training (short one NA from 9:00 p.m. to 10:30 p.m.), one nurse from 2:00 p.m. to 10:30 p.m. and one nurse from 2:00 p.m. to 8:30 p.m. (short one nurse from 8:30 p.m. to 10:30 p.m.)</p>	2 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 800	<p>Continued From page 22</p> <p>7/20/23 night shift 10:00 p.m. to 2:30 a.m. two NA's with one in training and 2:30 a.m. to 6:30 a.m. one NA with one in training (short NA from 2:30 a.m. to 6:30 a.m.)</p> <p>7/21/23 day shift 6:00 a.m. to 2:30 p.m. two NA and two nurses with one training (short NA 6:00 a.m. to 10:30 p.m.)</p> <p>7/21/23 evening shift 2:00 p.m. to 9:00 p.m. three NA's, 9:00 p.m. to 10:30 PM two NA's (short NA from 9:00 p.m. to 10:30 p.m.) and 2:00 p.m. to 10:30 PM one nurse, 2:00 p.m. to 8:30 p.m. (short nurse from 8:30 p.m. to 10:30 p.m.)</p> <p>7/22/23 day shift 6:00 a.m. to 2:30 p.m. one float NA and 7:00 a.m. to 2:30 p.m. one NA, and one nurse. (short NA from 6:00 a.m. to 7:00 a.m. and 9:30 a.m. to 10:30 a.m. and short two NA's from 10:30 a.m. to 2:30 p.m.) one nurse 6:00 a.m. to 7:15 a.m. two nurses from 7:15 a.m. to 8:30 a.m., three nurses 8:30 a.m. to 10:30 a.m., two nurses 10:30 a.m. to 2:30 p.m. (short nurse from 6:00 a.m. to 7:15 a.m.)</p> <p>7/22/23 evening shift three NA's from 2:00 p.m. to 4:30 p.m., 2:00 p.m. to 6:00 p.m. three NA's, 6:00 p.m. to 7:30 p.m., two NA's 7:30 p.m. to 9:00 p.m., one NA 9:00 p.m. to 10:30 p.m. (short NA 7:30 p.m. to 9:00 p.m. and short two NA's from 9:00 p.m. to 10:30 p.m.)</p> <p>Facility daily census dated 7/28/23, identified:</p> <ul style="list-style-type: none"> -current census on second floor 33 residents -9 residents independent -12 residents required assistance of one staff to 	2 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

2 800	<p>Continued From page 23</p> <p>transfer</p> <p>-12 residents required assistant of two staff to transfer</p> <p>Facility policy titled Sufficient Staffing dated 6/30/20 identified sufficient staffing would be provided to assure adequate staff are available to provide quality nursing care. Nursing direct care staffing ratios will be figured daily with changes in census and level of care needs made based on number of residents and the level of care necessary with administrator approval. Random scheduled resident interviews are conducted to assess satisfaction with care needs being met and considered when staffing ratios were determined.</p> <p>The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty one (21) days.</p>	2 800		
21805	<p>MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac. Bill of Rights</p> <p>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.</p>	21805		8/28/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 24</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure call lights were answered in a timely manner that promoted dignity for 8 of 10 (R1, R2, R4, R5, R6, R7, R8, and R11) reviewed.</p> <p>Findings include:</p> <p>R1's five-day assessment Minimum data set (MDS) dated 6/27/23, identified moderately impaired cognition with no behaviors. R1 required extensive assistance of for bed mobility, transfers, personal hygiene, toileting, and dressing and was independent in wheelchair for locomotion. R1 was always continent of bladder and occasionally incontinent of bowel. R1 received diuretics (increased production of urine) seven days out of seven days of the look back period.</p> <p>R1's care plan dated 7/28/23, identified R1 required extensive assist of two staff with the sit to stand lift for transfers. R1 was continent of bladder, rarely incontinent but did happen.</p> <p>R1's Kardex dated 7/28/23, identified R1 required extensive assistance of one with toilet use and extensive assistance of two with the sit to stand lift. Staff were instructed to turn and reposition R1 every two hours.</p> <p>The call light response time log was requested and reviewed for the date range of 7/21/23 through 7/25/23. Review of the call light response times for R1 revealed his call light was not responded to in a timely manner on the following dates:</p>	21805	Corrected	
-------	---	-------	-----------	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 25</p> <p>On 7/21/23, the call light was activated at 7:01 p.m. and was responded to 29 minutes 09 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 9:48 p.m. and was responded to 23 minutes 11 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:15 a.m. and was responded to 22 minutes 0 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 8:22 a.m. and was responded to 1 hour 2 minutes 36 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:20 p.m. and was responded to 31 minutes 10 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 6:09 p.m. and was responded to 30 minutes 27 seconds after it was activated.</p> <p>During an observation on 7/28/23 at 12:47 p.m. R1 wheeled himself around in wheelchair approached surveyor in the hallway by the entry way. R1 stated tried to find someone to help him to the bathroom, but seemed liked when he looked, they all disappeared. R1 then approached an unidentified staff who was pushing a mechanical lift machine down the hallway. R1 asked the staff if he could get help going to the bathroom. The staff stated my partner was on break and there were only two staff on the floor working right now so R1 would have to wait at least another 20 minutes before he could be helped and walked away. R1 pushed himself over to the television room and said out loud, "geez</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 26</p> <p>hope I can wait that long."</p> <p>During an interview on 7/15/23 at 2:15 p.m. R1 stated they were a morning person and wanted to be up by 6:30 a.m., usually placed call light on but the staff were slow to answer, and sometimes had to wait up to 20 minutes in the morning to get up. R1 verified staff came in, shut call light off, said they would come back, and had taken a while before they returned. R1 also stated there were times when it had taken much longer to get help, up to an hour, and usually fell asleep waiting for them to help.</p> <p>R2's significant change MDS dated 6/9/23 identified intact cognition and no behaviors. R2 had diagnoses of anxiety and congestive heart failure (CHF). R2 required extensive assistance of one for bed mobility, personal hygiene, and dressing and extensive assistance of two for transfers and toilet use. R1 was frequently incontinent of bowel and bladder. R1 received diuretics (increased production of urine) seven out of seven days during the look back period.</p> <p>R2's care plan date 7/28/23, identified staff were directed to reposition resident at least every two hours per tolerance and schedule.</p> <p>R2's Kardex dated 7/28/23, identified R2 required assist of one staff for toileting and was incontinent of bowel and bladder at times.</p> <p>R2's bladder assessment completed on 7/18/23, identified R2 was always incontinent of urine and voiding pattern after breakfast, lunch, supper, and at bedtime.</p> <p>R2's bladder urinary continence record from 7/20/23, through 7/25/23, identified:</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 27</p> <p>-7/20/23 incontinent 2:27 a.m., 10:00 a.m., and 3:03 p.m. -7/21/23 incontinent 12:11 a.m. and 5:46 p.m. -7/22/23 incontinent 1:39 p.m., 1:59 p.m., and 2:46 p.m. -7/23/23 continent 5:31 a.m. and incontinent 10:22 a.m. and 2:37 p.m. -7/24/23 incontinent 12:04 a.m., 9:30 a.m., and 9:59 p.m. -7/25/23 incontinent 1:43 a.m., 9:28 a.m., and 5:42 p.m.</p> <p>R2's call light response time log was requested and reviewed for the date range of 7/22/23 through 7/25/23. Review of the call light response times for R2 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/22/23, the call light was activated at 5:48 p.m. and was responded to 22 minutes 11 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 9:47 p.m. and was responded to 29 minutes 17 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:15 a.m. and was responded to 22 minutes 0 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:58 a.m. and was responded to 26 minutes 01 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 2:06 p.m. and was responded to 20 minutes 37 seconds after it was activated.</p>	21805		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 28</p> <p>On 7/24/23, the call light was activated at 6:09 p.m. and was responded to 25 minutes 39 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:20 p.m. and was responded to 31 minutes 10 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 6:09 p.m. and was responded to 30 minutes 27 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 7:24 p.m. and was responded to 26 minutes 55 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 8:38 p.m. and was responded to 30 minutes 28 seconds after it was activated.</p> <p>During an interview on 7/25/23 at 3:15 p.m. R2 stated staff came into their room, turned off call light and told me they would be right back, and no one came back. R2 indicted she then turned the call light on again 30 minutes later and staff repeated the same process. R2 verified it would take up to three hours to put her back to bed or get her up at times. R2 stated she knew staff were busy but counted on their word when they told her they would be right back and after a while they need to come back and take care of those they forgot. R2 also stated she felt like she had been forgotten and indicated she had complained to nurses, NA's and the social worker. R2 stated she hesitated to put on the call light when staff were so busy, staff made her feel like she made it harder on them when she used the call light, and she became frustrated. R2 identified they could do better but hard to do when short staffed frequently. R2 stated when she sat up too long</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 29</p> <p>her legs would swell up and feet went numb. R2 indicted the long wait times seemed to be worse in the afternoons between supper and 10:00 p.m., staff ran ragged and complained about how they were over worked. R2 stated once she was back in bed it became even harder to get staff to answer the call light to get help.</p> <p>During an observation on 7/26/23 at 8:30 a.m. R2 laid in bed and breakfast tray located on a bedside table, remained untouched and unreachable. At 8:56 a.m. dietary staff entered R2's room and attempted to removed breakfast tray from bedside table. R2 stated "No do not take that I have not eaten yet, the table was too far away". Dietary exited the room and R2's breakfast tray remained unreachable. At 8:57 a.m. R2 waved an unidentified staff over to her and requested the table be pulled closer to her so she could eat her breakfast. Staff assisted R2.</p> <p>R4's quarterly MDS dated 6/27/23, identified intact cognition and no behaviors. R4 required extensive assistance for bed mobility, transfers, personal hygiene, toileting, and dressing and total dependence for locomotion. R4 was always incontinent of bowel and bladder, high risk for pressure ulcers, and turn/reposition program.</p> <p>R4's care plan dated 7/28/23, identified R4 had alterations in elimination related to a history of cerebral infarction (stroke), hemiplegia (weakness on one side of the body), spinal stenosis (narrowing), and incontinent of bladder at times. R4's care plan directed staff to provide incontinence care due to bowel and bladder incontinence to have kept R4 clean, dry, and odor free daily through staff assistance and interventions. R4 received diuretics (increased production of urine) seven out of seven days.</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 30</p> <p>R4's Kardex dated 7/28/23, identified R4 required assistance with turning every two hours and as needed, check and change and bedpan offered due to bowel and bladder incontinence. R4 required assist of two staff and a total lift to transfer.</p> <p>R4's bladder assessment dated 6/25/23, identified conditions impacted urinary continence status included cerebral vascular accident, obesity, pain, and diabetes. R4 had functional incontinence (related to inability to toilet due to cognitive or physical functioning). R4's perception of the need to void was absent and required physical assistance in toileting.</p> <p>R4's bladder urinary continence record from 7/20/23, through 7/25/23, identified:</p> <ul style="list-style-type: none"> -7/20/23, incontinent 9:52 p.m. and 5:15 p.m. -7/21/23, incontinent 12:06 a.m., 12:31 p.m., and 8:55 p.m. -7/22/23, incontinent 12:56 a.m., 1:59 p.m., and 2:38 p.m. -7/23/23, incontinent 5:25 a.m., 12:57 p.m., and 2:50 p.m. -7/24/23, incontinent 12:02 a.m., 9:32 a.m., and 9:52 p.m. -7/25/23, incontinent 1:38 a.m., 9:30 a.m., and 5:10 p.m. <p>R4's bowel assessment dated 6/25/23, identified always incontinent of bowel.</p> <p>R4's call light response time log was requested and reviewed for the date range of 7/23/23 through 7/26/23. Review of the call light response times for R4 revealed her call light was not responded to in a timely manner on the following</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 31</p> <p>dates:</p> <p>On 7/23/23, the call light was activated at 6:31 a.m. and was responded to 21 minutes 15 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:11 a.m. and was responded to 22 minutes 22 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 9:26 a.m. and was responded to 20 minutes 08 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 10:15 a.m. and was responded to 24 minutes 31 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 2:00 p.m. and was responded to 17 minutes 31 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 6:43 a.m. and was responded to 34 minutes 07 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 2:09 p.m. and was responded to 31 minutes 21 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 2:03 p.m. and was responded to 37 minutes 28 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 5:17 p.m. and was responded to 32 minutes 0 seconds after it was activated.</p> <p>On 7/26/23, the call light was activated at 5:34 a.m. and was responded to 20 minutes 44</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 32</p> <p>seconds after it was activated.</p> <p>During an interview on 7/25/23 at 10:35 a.m. R4 laid in bed and stated she had been laying in urine and stool for at least four hours now. R4 alleged staff had not been checked and changed her since around 2:00 a.m. and that happened almost every day. (see R4's bladder urinary continence record above). R4 indicated she required assistance with cares and was unable to walk. R4 stated she would like to have received morning cares earlier today but found it difficult to get assistance from staff. R4 stated the lack of staff assistance had been going on for about four months now. R4 indicated the bed sheets were generally changed every day due to wet sheets from urine, she laid there too long. R4 stated on Saturdays she hollered for staff and reminded them she needed her shower otherwise was forgotten. R4 indicated she had placed her call light on, waited up to one hour, staff came in, shut off call light, and told R4 they would be back, and did not return. R4 stated it "broke her heart" she could not get the help she needed. R4 stated she wanted to be up out of bed and in her chair daily, and staff informed her they did not have time to get her up, so she stayed in bed.</p> <p>During an observation on 7/25/23 at 10:55 a.m. R4 placed her call light on and NA-C answered in at 11:09 a.m. R4 asked to be changed and NA-C stated your sheets needed to be changed, required another staff to assist, and exited the room.</p> <p>During an observation and interview on 7/25/23 at 11:45 a.m. (35 minutes later) NA-C and NA-D entered R4's room and applied gloves. NA-D and NA-C completed cares for R4. NA-D confirmed the brief had stool smeared on it and 50 percent</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 33</p> <p>saturated with urine. ND-C removed the sheets from R4's bed and placed them in a clear bag.</p> <p>R5's Significant change MDS dated 7/10/23, identified intact cognition and no behaviors. R5 required extensive assistance with personal hygiene, limited assistance with toileting, and supervision with transfers. R5 was always continent of bowel and bladder. R5's diagnoses included anxiety disorder, depression, and schizophrenia. R5 received a diuretic seven out of seven days of the look back period.</p> <p>R5's care plan dated 7/28/23, identified R5 had a ADL self-care deficit due to rheumatoid arthritis, diabetes mellitus, physical deconditioning, paranoid schizophrenia, morbid obesity, and poor eye sight. Staff were directed to assist R5 with bathing, dressing, toilet use, bed mobility, transfers assist of one in the morning and two assist after 8:00 p.m., and approach R5 warmly, positively, empathy, and understanding to bolster self-coping skills.</p> <p>R5's Kardex dated 7/28/23, identified R5 required assist of one to use toilet and complete personal hygiene.</p> <p>R5's bowel continence floor sheet dated 7/28/23 identified:</p> <p>-7/16/23 at 1:59 p.m. incontinent of bowel -7/26/23 at 9:31 p.m. incontinent of bowel</p> <p>R5's call light response time log was requested and reviewed for the date range of 7/5/23 through 7/12/23. Review of the call light response times for R5 revealed her call light was not responded to in a timely manner on the following dates:</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 34</p> <p>On 7/5/23, the call light was activated at 9:48 a.m. and was responded to 25 minutes 12 seconds after it was activated.</p> <p>On 7/6/23, the call light was activated at 9:38 a.m. and was responded to 32 minutes 15 seconds after it was activated.</p> <p>On 7/7/23, the call light was activated at 9:21 a.m. and was responded to 22 minutes 05 seconds after it was activated.</p> <p>On 7/8/23, the call light was activated at 1:46 p.m. and was responded to 19 minutes 07 seconds after it was activated.</p> <p>On 7/11/23, the call light was activated at 8:07 p.m. and was responded to 17 minutes 47 seconds after it was activated.</p> <p>On 7/12/23, the call light was activated at 3:12 p.m. and was responded to 25 minutes 25 seconds after it was activated.</p> <p>During an interview and observation on 7/26/23 at 9:17 a.m., R5 sat in wheelchair with only a shirt and brief on and no shoes or slippers. R5 stated she had placed her call light on and had been waiting for assistance to wipe up the floor where she spilled her breakfast juice on her lap and then onto the floor. R5 stated staff took up to one hour to respond to the call light. R4 verified it had been hard to get help with anything especially on the evening and night shift, which seemed like staff did not want to come and answer it. R5 stated she had not complained about this, as she did not want to get any staff in trouble, but it made her mad and frustrated. R5 indicated she had a hard time getting fresh water, had waited up to 3 hours, and could pretty much do everything else</p>	21805		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
21805	<p>Continued From page 35</p> <p>for herself. At 9:37 a.m. (20 minutes later) NA-A knocked on door, entered the room and asked what she needed. R5 stated her wet pants needed to be picked up and NA-A stated, "oh is that all you needed?" NA-A cleaned up the floor with a towel and exited the room. R5 stated she tried to do as much for herself as possible but was unable to complete her own peri cares and it was hard to get a staff to help. R5 added, staff have told her evening cares would be completed at 9:00 p.m. but staff do not come in until 10:00 p.m. Lastly, R5 added, her anxiety level increase when call light response times take so long and this affects her mental health.</p> <p>R5's call light log on 7/26/23, the call light was activated at 9:17 a.m. and was responded to 20 minutes 59 seconds after it was activated.</p> <p>R6's Significant change MDS date 5/15/23, identified intact cognition and no behaviors. R6 required extensive assistance with bed mobility, dressing, personal hygiene, and toileting and total dependence on staff for transfers. R6 was frequently incontinent of bladder and occasionally incontinent of bowel. R6's diagnoses included anxiety and manic depression.</p> <p>R6's care plan dated 7/28/23, identified R6 had limited physical mobility related to muscle weakness, deformities of the foot, essential tremors, morbid obesity, chronic pain, fibromyalgia, and contractures of the left hand. R6's care plan directed staff to transfer R6 full body lift and assistance of two staff and routinely turn an reposition at least every two hours.</p> <p>R6's Kardex dated 7/28/23, identified, R6 needed encouragement to off load and/or change positions at least every 2 hours and incontinent of</p>	21805		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 36</p> <p>bladder at times.</p> <p>R6's call light response time log was requested and reviewed for the date range of 7/21/23 through 7/24/23. Review of the call light response times for R6 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/21/23, the call light was activated at 6:33 p.m. and was responded to 55 minutes 25 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 8:02 a.m. and was responded to 56 minutes 22 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 6:35 p.m. and was responded to 49 minutes 33 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 9:09 p.m. and was responded to 31 minutes 33 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:57 a.m. and was responded to 38 minutes 22 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 9:41 a.m. and was responded to 25 minutes 54 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 6:17 p.m. and was responded to 38 minutes 25 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 7:41 a.m. and was responded to 1 hour 13 minutes 7 seconds after it was activated.</p>	21805		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
21805	<p>Continued From page 37</p> <p>On 7/24/23, the call light was activated at 5:58 p.m. and was responded to 1 hour 51 minutes 45 seconds after it was activated.</p> <p>During an interview/observation on 7/25/23 at 12:40 p.m. R6's call light was on. Activity staff walked down hallway past R6's room, entered a neighbor's room, and did not answer R6's call light. R6 stated she had placed call light on a bit ago, NA-A came in and turned call light off, informed R6 she would look for another staff to help her. R6 stated she had waited up to approximately 30 to 45 minutes, no staff came, placed call light on again. R6 stated another staff came and answered her call light and informed her NA-A did not say anything about you needed help. R6 confirmed she had urine accidents, it had been a while, she tried to hold it until staff could get here to help her. R6 stated staff got upset when she would ask for many small things usually the evening and nighttime shifts. R6 stated she has been told by staff they have other people to take care of, get to the point, and are in a rush to leave her room. R6 stated she understood they are busy but would it only took a few minutes to help her and they made her feel like she was a burden to them.</p> <p>R7's Admission MDS dated 7/12/23, identified intact cognition and no behaviors. R7 required extensive assistance with bed mobility, dressing, toilet use, personal hygiene and total dependence with transfers. R 7 was frequently incontinent of bowel and bladder with a history of urinary tract infections.</p> <p>R7's care plan dated 7/18/23, identified R7 had an ADL self-care deficit related to osteoporosis pain, muscle spasms, weakness, and</p>	21805		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 38</p> <p>deconditioning. Staff were instructed to provide assist of two with sit to stand lift, keep pressure off of left lower heel/extremity, and may use bedside commode for toileting.</p> <p>R7's call light response time log was requested and reviewed for the date range of 7/16/23 through 7/21/23. Review of the call light response times for R7 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/16/23, the call light was activated at 7:33 a.m. and was responded to 22 minutes 41 seconds after it was activated.</p> <p>On 7/17/23, the call light was activated at 11:13 a.m. and was responded to 17 minutes 45 seconds after it was activated.</p> <p>On 7/18/23, the call light was activated at 3:10 p.m. and was responded to 19 minutes 47 seconds after it was activated.</p> <p>On 7/19/23, the call light was activated at 8:12 a.m. and was responded to 19 minutes 12 seconds after it was activated.</p> <p>On 7/19/23, the call light was activated at 9:30 p.m. and was responded to 22 minutes 08 seconds after it was activated.</p> <p>On 7/21/23, the call light was activated at 4:33 a.m. and was responded to 17 minutes 39 seconds after it was activated.</p> <p>Interview on 7/26/23 at 1:20 p.m., R7 laid in bed on her back. R7 stated the call light wait times get to be long in the morning because they are short staffed. R7 stated two weeks ago, she placed her</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 39</p> <p>call light on early in the morning around just after 9:00 a.m. and took staff over 20 minutes later staff came in, turned off call light, informed her they would be right back, and staff returned much later. R7 stated she laid in bed from 7:00 a.m. to 10:30 a.m. incontinent of urine, and wanted to be up by at least 9:00 a.m. R7 stated she has to wait up to two hours to get laid down and staff tell me they will help, but do not come back. R7 stated she felt so helpless and unable to get help when needed.</p> <p>On 7/12/23, R7's call light was activated at 9:12 a.m. and was responded to 25 minutes 33 seconds after it was activated.</p> <p>Review of R7's urinary continence dated 7/12/23 at 10:37 a.m. R7 was incontinent of urine.</p> <p>R8's Significant change MDS dated 6/27/23, identified intact cognition and no behaviors. R8 required extensive assistance with bed mobility, dressing, and toilet use and limited assistance with personal hygiene and transfers. R8 was occasionally incontinent of bladder and always continent of bowel. R7 received a diuretic 7 out of 7 days during the look back period.</p> <p>R8's care plan dated 7/28/23, identified an ADL self-care deficit related to chronic right shoulder pain and obesity. Staff were instructed to provide assistance with peri cares to help avoid further urinary tract infections and check and change as needed due to incontinence.</p> <p>R8's Kardex identified required assistance of one for bathing and assistance with lower body cleansing.</p> <p>R8's call light response time log was requested</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 40</p> <p>and reviewed for the date range of 6/29/23 through 7/7/23. Review of the call light response times for R8 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 6/29/23, the call light was activated at 6:14 a.m. and was responded to 40 minutes 2 seconds after it was activated.</p> <p>On 6/29/23, the call light was activated at 7:39 a.m. and was responded to 37 minutes 12 seconds after it was activated.</p> <p>On 7/1/23, the call light was activated at 6:13 a.m. and was responded to 30 minutes 19 seconds after it was activated.</p> <p>On 7/2/23, the call light was activated at 8:50 a.m. and was responded to 21 minutes 01 seconds after it was activated.</p> <p>On 7/5/23, the call light was activated at 8:40 a.m. and was responded to 15 minutes 10 seconds after it was activated.</p> <p>On 7/6/23, the call light was activated at 7:32 a.m. and was responded to 1 hour 14 minutes 39 seconds after it was activated.</p> <p>On 7/7/23, the call light was activated at 7:40 a.m. and was responded to 20 minutes 12 seconds after it was activated.</p> <p>During an interview on 7/26/23 at 12:51 p.m. R8 stated they are short staffed quite often, especially on weekends. R8 stated this past Saturday on 7/22/23, staff called in sick and there was (verified by schedule)only one staff on the floor for about two hours. R8 indicated she did</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 41</p> <p>had not received her scheduled shower that day. R8 stated last evening on 7/25/23, NA-A arrived in her room and instructed her to turn the call light off. R8 stated she asked NA-A for a gown and assistance with evening cares, NA-A left the room and did not return. R8 stated she placed call light on again that evening but no one came so R8 turned off light, and fell asleep in her clothing. R8 stated she does not feel the facility has enough staff to meet our needs. R8 stated earlier this month, used call light early in the morning, and waited up to over an hour for assistance. R8 also stated on 7/26/23, she had been yelled at by an NA at 6:30 a.m. when she placed her call light on before 6:30 a.m. and was told to not to use the call light prior to 6:30 a.m., staff were in report. R8 stated she waited until closer to 8:00 a.m. placed the call light on again and received assistance. R8 stated had not told any one because it would not do any good. R8 stated she would have told the social worker but had previously talked to her, and had not received much help. R8 indicated she does usually attended the resident counsel meeting, but was in too much pain to attend the last one. R8 had brought up concerns during a previous resident counsel meeting and nothing was really resolved.</p> <p>Review of facility staff schedule day shift on 7/22/23 identified: day shift 6:00 a.m. to 2:30 p.m. one float NA and 7:00 a.m. to 2:30 p.m. one NA, and one nurse. (short NA from 6:00 a.m. to 7:00 a.m. and 9:30 a.m. to 10:30 a.m. and short two NA's from 10:30 a.m. to 2:30 p.m.) one nurse 6:00 a.m. to 7:15 a.m. two nurses from 7:15 a.m. to 8:30 a.m., three nurses 8:30 a.m. to 10:30 a.m., two nurses 10:30 a.m. to 2:30 p.m. (short nurse from 6:00 a.m. to 7:15 a.m.)</p>	21805		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 42</p> <p>Review of the call light times for R8 revealed on 7/26/23, her call light was activated at 6:27 a.m. and not again until 7:50 a.m.:</p> <p>On 7/26/23, the call light was activated at 6:27 a.m. and was responded to 13 minutes 3 seconds after it was activated.</p> <p>On 7/26/23, the call light was activated AT 7:50 a.m. and was responded to 41 seconds after it was activated.</p> <p>R8's shower/bathing record indicated no shower/bath was documented as completed on 7/22/23.</p> <p>During an interview on 7/26/23 at 2:07 p.m. NA-A stated did not assist R8 with evening cares last night on 7/25/23 and did not recall answering R8's call light. NA-A stated R8 does not need help with cares anyway.</p> <p>Review of the call light times for R8 on 7/25/23, revealed her call light was activated:</p> <p>-at 7:41 p.m. and responded to 8 minutes 2 seconds</p> <p>-at 7:53 p.m. and responded to 18 minutes 19 seconds</p> <p>-at 8:11 p.m. and responded to 5 minutes 10 seconds</p> <p>R8's call light was not activated again on 7/25/23, until 2:08 a.m.</p> <p>R11's Significant change MDS dated 7/26/23, identified intact cognition and no behaviors. R11 required extensive assistance for bed mobility,</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 43</p> <p>transfers, personal hygiene, toileting, dressing, and locomotion. R11 was occasionally incontinent of bladder and frequently incontinent of bowel with a history of bladder infections.</p> <p>R11's care plan dated 7/28/23, identified R11 had an activities of daily living (ADL) self-care deficit related to contractures of bilateral hands, altered mental status, low back pain, and weakness. R11 required assist of two staff for toilet us. Staff were directed to offer toileting every two hours.</p> <p>R11's Kardex dated 7/28/23, identified R11 required assist of two and EZ stand to transfer and offer toileting every two hours and document refusals.</p> <p>R11's Bladder evaluation dated 7/26/23, identified frequently incontinent due to memory problems, impaired decision making, required physical assistance in toileting, obesity, and diabetes. R11's perception of need to void was diminished.</p> <p>R11's call light response time log was requested and reviewed for the date range of 7/23/23 through 7/25/23. Review of the call light response times for R11 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/22/23, the call light was activated at 9:11 p.m. and was responded to 29 minutes 05 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 7:21 a.m. and was responded to 31 minutes 15 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 1:25 p.m. and was responded to 20 minutes 11</p>	21805		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 44</p> <p>seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 10:59 p.m. and was responded to 20 minutes 31 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 10:59 p.m. and was responded to 20 minutes 31 seconds after it was activated.</p> <p>On 7/26/23, the call light was activated at 8:48 a.m. and was responded to 30 minutes 41 seconds after it was activated.</p> <p>During an interview on 7/26/23 at 1:39 p.m. R11 stated placed call light on this morning around 8:45 a.m. and had taken staff over 30 minutes for the staff to respond. R11 also stated call light did not seem to work at times with how long she had waited for staff to answer it. R11 stated she required assistance of staff and a stand lift to get up to the commode, waited too long, and resulted in urine and stool accidents.. R11 stated when she went in her pants did not feel very good about it and was embarrassed. R11 stated she had placed the call light on at about 1:15 p.m., and now it is 1:45 p.m., with no staff having answered it yet. R11 indicated she tried to hold her urine as long as she could, currently had urinary tract infection, and this had become difficult to do. R11 requested surveyor please let staff know she needed help to the bathroom, not sure how much longer she could hold it before she had an accident in her pants. Interview ended at 1:45 p.m.</p> <p>Observation on 7/26/23 at 1:52 p.m. two call lights R6 and R11 had been on since 1:45 p.m. located in the same hallway. NA-A walked down this hallway to the room next to R11's room</p>	21805		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 45</p> <p>carrying clean linen, walked into the neighbor's room and closed the door. Seven minutes later at 1:55 p.m. NA-A walked out of that room, did not answer R6's or R11's call lights and walked down the hallway to the nurse's station slowly.</p> <p>Observation on 7/26/23 at 1:55 p.m. NA-B walked into R11's room, shut off call light, said she would find someone to help her, and exited the room. NA-B then walked into R6's room, shut off call light, said she would find someone to help her and be back, and exited the room. NA-B walked down hallway to the nurse's station and did not return to R11's or R6's rooms during this observation.</p> <p>Observation on 7/26/23 at 2:01 p.m. NA-G walked down hallway and into R11's room and stated you need to go to the bathroom? R11 stated yes, really bad. NA-G exited the room waked down hallway and returned to R11's room at 2:03 p.m. NA-G placed gloved hands and informed R11 they had to wait for assistance of another staff. At 2:10 p.m. NA-A entered R11's room, placed gloves on hands, raised resident up off wheelchair with the sit to stand lift, and lowered her onto the commode. NA-G verified R11's brief was dry, gave R11 a call light, exited the room. NA-A and NA-G did not enter R6's room across the hallway and walked towards the nurse's station.</p> <p>During an interview on 7/25/23 at 1:00 p.m. NA-C explained day shift received report on all residents, answered call lights, completed cares first on the residents required assistance of two, then assisted residents who required assistance of one to get up, and lastly assisted the other residents when help was needed. NA-C indicated staff were not assigned to specific residents and</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 46</p> <p>did not get residents up by time preference. NA-C stated there was a cheat sheet listed of all residents located at the nurse's station. NA-C stated all staff were required to cross names off as cares were completed on each resident. NA-C indicated all residents should have been checked and changed every two hours. NA-C stated some residents placed their call light on when assistance was needed for toileting however, resident unable to should have been checked and changed every two to two and half hours. NA-C stated staff were expected to answer call lights within two to three minutes.</p> <p>During an interview on 7/25/23 at 2:13 p.m. NA-A stated day shift received report on all residents, completed cares on residents required assist of two first and another staff completed showers. NA-A indicated staff were not assigned to specific residents.</p> <p>During an interview on 7/26/23 at 2:34 p.m., NA-E stated they needed more staff to complete all tasks. NA-E stated they had answered one residents call light 15 times already this shift. NA-E indicated there were times when a resident only needed something simple like a television channel changed or asked to be covered up. NA-E confirmed approximately one half of the residents were incontinent of urine by the time they got to them today. NA-E confirmed floor nurses did not answer call lights but trained medication aids (TMA) answered call lights occasionally.</p> <p>During a follow up interview on 7/27/23 at 9:51 a.m., NA-E indicated it was hard to keep up with meeting the resident's basic needs such as toileting and bathes when not enough staff were scheduled. NA-E verified only two staff worked</p>	21805		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 47</p> <p>today along with one person training. NA-E also indicated occasionally a NA floated between the two floors and helped out.</p> <p>During an interview on 7/28/23 at 12:56 p.m., assistant director of nursing (ADON) stated they were not aware of any concerns staff regarding staffing and expected the staffing scheduler to have filled the schedule. ADON also stated call lights averaged much less than 10 minutes and audits would have been completed by the social worker. ADON expected staff to prioritize how quickly they answered the call lights and go to the residents first with safety issues. ADON expected staff to take care of the residents and was unable to place a length of time on the expectation regarding answering call lights.</p> <p>During an interview on 7/28/23 at 1:26 p.m. social worker (SW) stated staff and residents had complained about long call light times. SW indicated the entire second floor was looked at for one week regarding long call wait times and majority of the call lights were under 15 minutes, some longer, and one was 30 minutes. SW stated these results were shared with DON and ADON and talked about the findings, no notes were taken during this audit or meeting. SW stated they had planned a weekly call light audit for the next three weeks, so the long call light wait times and any trends or specific rooms could be addressed accordingly. SW stated up to a 30 minute wait time would be the maximum time a resident should have to wait for the call light to be answered.</p> <p>During an interview on 7/28/23 at 1:44 p.m. LPN-B stated there were not sufficient staff to meet the needs of resident and provide safe care especially when residents were first admitted.</p>	21805		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 48</p> <p>LPN-B stated facility had a high turnover rate of residents with a high acuity. LPN-B stated frequently only two NA's would be scheduled to care for over 30 residents and needs such as toileting and basic cares were not being met.</p> <p>During an interview on 7/28/23 at 1:52 p.m., NA-F stated staffing was an issue, adding two NA's were not enough to care for 33 residents. NA-F indicated they felt rushed through all cares and was unable to take the time needed to care for residents properly. NA-F stated our equipment such as lifts do not work properly, batteries are worn out, and residents are up in the air longer than they should be. NA-F verified approximately 75% of the residents were already incontinent prior to getting assistance from staff due to the length of time it took to get to each one and that should not be happening. NA-F stated most of the time when the facility is short staffed it is due to call ins. NA-F indicated they work three double shifts a week due to shortage of staff. NA-F also stated resident wait times are longer than they should be due to staff turning off the call light, informed resident they will return with help, then get busy, and forget to go back to assist them.</p> <p>During an interview on 7/28/23 at 4:15 p.m. director of nursing (DON) stated expected all staff to answer call lights and included administration, maintenance, and dietary. DON stated when non-direct care employee answered a call light they were expected to find help to meet the resident's needs. DON indicated expectations related to call light response time varied from resident to resident. DON confirmed audits had been completed before and some residents had said an hour response time was fine, others said 10 minutes, 20 minutes, and 30 minutes. DON verified she had reviewed a multitude of call light</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

21805	<p>Continued From page 49</p> <p>audits in the past, they were really good response times, and then there were some that had longer during high call times such as before and after meals and at bedtime DON stated call light times varied and depended on the resident. DON also stated personally, call light response time should be within 10 minutes but varied with each resident and their needs</p> <p>Resident Council Meeting Minutes dated 7/19/23, identified eight residents attended (included R1, R2, R5, R6). Current situation/concern call lights not being answered in a timely manner. Need a faster response time. Nursing and social services would be expected to help resolve this current concern.</p> <p>Facility policy titled Call Light Use and Response dated 7/18/23, identified staff were expected to respond promptly to resident's call for assistance. All facility personnel must be aware of call lights at all times, answer call lights promptly whether or not the staff person was assigned to the resident or not. Answer all call lights in a prompt, calm, courteous manner; turn off call light as soon as you enter the room and attend to the resident's needs. Consider a quality assurance and assessment program to check the call light system at regular intervals.</p> <p>SUGGESTED METHOD OF CORRECTION: The facility could review their education and training in providing dignified care of vulnerable adults and review/implement policies and procedures for assuring dignified care. The facility could provide ongoing education and training and monitor for compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21805		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/28/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 7/25/23, through 7/28/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55813922C (MN00095406) H55814004C (MN00095408) H55814002C (MN00095174) with deficiencies issued at F550, F690 and F725 As a result of the investigation, deficiency was cited at F880 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		8/28/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/25/2023

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.

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 1</p> <p>outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure call lights were</p>	F 550	<p>F550 The facility failed to ensure call lights were</p>	

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 2</p> <p>answered in a timely manner that promoted dignity for 8 of 10 (R1, R2, R4, R5, R6, R7, R8, and R11) reviewed.</p> <p>Findings include:</p> <p>R1's five-day assessment Minimum data set (MDS) dated 6/27/23, identified moderately impaired cognition with no behaviors. R1 required extensive assistance of for bed mobility, transfers, personal hygiene, toileting, and dressing and was independent in wheelchair for locomotion. R1 was always continent of bladder and occasionally incontinent of bowel. R1 received diuretics (increased production of urine) seven days out of seven days of the look back period.</p> <p>R1's care plan dated 7/28/23, identified R1 required extensive assist of two staff with the sit to stand lift for transfers. R1 was continent of bladder, rarely incontinent but did happen.</p> <p>R1's Kardex dated 7/28/23, identified R1 required extensive assistance of one with toilet use and extensive assistance of two with the sit to stand lift. Staff were instructed to turn and reposition R1 every two hours.</p> <p>The call light response time log was requested and reviewed for the date range of 7/21/23 through 7/25/23. Review of the call light response times for R1 revealed his call light was not responded to in a timely manner on the following dates:</p> <p>On 7/21/23, the call light was activated at 7:01 p.m. and was responded to 29 minutes 09 seconds after it was activated.</p>	F 550	<p>answered in a timely manner that promoted dignity for 8 of 10 residents (R1, R2, R4, R5, R6, R7, R8, and R11) reviewed.</p> <ol style="list-style-type: none"> 1. Facility reviewed call light reports for R1, R2, R4, R5, R6, R7, R8, and R11 for 30 days to determine patterns of concerns. 2. Every resident in the facility has the potential of being affected by this deficient practice. 3. Interdisciplinary Team implemented scheduled break times for CNAs with the expectation that no CNAs are to take breaks together to provide more supervision on the floor. CNAs are to sign in and out with the nurse, or designee, for their breaks. Walkie Talkies were also implemented with sign-in and sign-out sheets supervised by a nurse, or designee, on the floor that shift. Staff educated on Dignity and Respect policy/resident rights, call light use and response policy, and abuse and neglect policy. 4. Audits developed to be completed and audited by the DON, or designee, 3x weekly for 4 weeks, then weekly for 2 months and will be presented at QAPI for review. Results of audits are reviewed timely and addressed as appropriate. 5. This deficiency will be corrected 8/28/23 	

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 3</p> <p>On 7/22/23, the call light was activated at 9:48 p.m. and was responded to 23 minutes 11 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:15 a.m. and was responded to 22 minutes 0 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 8:22 a.m. and was responded to 1 hour 2 minutes 36 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:20 p.m. and was responded to 31 minutes 10 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 6:09 p.m. and was responded to 30 minutes 27 seconds after it was activated.</p> <p>During an observation on 7/28/23 at 12:47 p.m. R1 wheeled himself around in wheelchair approached surveyor in the hallway by the entry way. R1 stated tried to find someone to help him to the bathroom, but seemed liked when he looked, they all disappeared. R1 then approached an unidentified staff who was pushing a mechanical lift machine down the hallway. R1 asked the staff if he could get help going to the bathroom. The staff stated my partner was on break and there were only two staff on the floor working right now so R1 would have to wait at least another 20 minutes before he could be helped and walked away. R1 pushed himself over to the television room and said out loud, "geez hope I can wait that long."</p> <p>During an interview on 7/15/23 at 2:15 p.m. R1</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 4</p> <p>stated they were a morning person and wanted to be up by 6:30 a.m., usually placed call light on but the staff were slow to answer, and sometimes had to wait up to 20 minutes in the morning to get up. R1 verified staff came in, shut call light off, said they would come back, and had taken a while before they returned. R1 also stated there were times when it had taken much longer to get help, up to an hour, and usually fell asleep waiting for them to help.</p> <p>R2's significant change MDS dated 6/9/23 identified intact cognition and no behaviors. R2 had diagnoses of anxiety and congestive heart failure (CHF). R2 required extensive assistance of one for bed mobility, personal hygiene, and dressing and extensive assistance of two for transfers and toilet use. R1 was frequently incontinent of bowel and bladder. R1 received diuretics (increased production of urine) seven out of seven days during the look back period.</p> <p>R2's care plan date 7/28/23, identified staff were directed to reposition resident at least every two hours per tolerance and schedule.</p> <p>R2's Kardex dated 7/28/23, identified R2 required assist of one staff for toileting and was incontinent of bowel and bladder at times.</p> <p>R2's bladder assessment completed on 7/18/23, identified R2 was always incontinent of urine and voiding pattern after breakfast, lunch, supper, and at bedtime.</p> <p>R2's bladder urinary continence record from 7/20/23, through 7/25/23, identified:</p> <p>-7/20/23 incontinent 2:27 a.m., 10:00 a.m., and</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 5</p> <p>3:03 p.m. -7/21/23 incontinent 12:11 a.m. and 5:46 p.m. -7/22/23 incontinent 1:39 p.m., 1:59 p.m., and 2:46 p.m. -7/23/23 continent 5:31 a.m. and incontinent 10:22 a.m. and 2:37 p.m. -7/24/23 incontinent 12:04 a.m., 9:30 a.m., and 9:59 p.m. -7/25/23 incontinent 1:43 a.m., 9:28 a.m., and 5:42 p.m.</p> <p>R2's call light response time log was requested and reviewed for the date range of 7/22/23 through 7/25/23. Review of the call light response times for R2 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/22/23, the call light was activated at 5:48 p.m. and was responded to 22 minutes 11 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 9:47 p.m. and was responded to 29 minutes 17 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:15 a.m. and was responded to 22 minutes 0 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:58 a.m. and was responded to 26 minutes 01 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 2:06 p.m. and was responded to 20 minutes 37 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 6:09</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 6</p> <p>p.m. and was responded to 25 minutes 39 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:20 p.m. and was responded to 31 minutes 10 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 6:09 p.m. and was responded to 30 minutes 27 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 7:24 p.m. and was responded to 26 minutes 55 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 8:38 p.m. and was responded to 30 minutes 28 seconds after it was activated.</p> <p>During an interview on 7/25/23 at 3:15 p.m. R2 stated staff came into their room, turned off call light and told me they would be right back, and no one came back. R2 indicted she then turned the call light on again 30 minutes later and staff repeated the same process. R2 verified it would take up to three hours to put her back to bed or get her up at times. R2 stated she knew staff were busy but counted on their word when they told her they would be right back and after a while they need to come back and take care of those they forgot. R2 also stated she felt like she had been forgotten and indicated she had complained to nurses, NA's and the social worker. R2 stated she hesitated to put on the call light when staff were so busy, staff made her feel like she made it harder on them when she used the call light, and she became frustrated. R2 identified they could do better but hard to do when short staffed frequently. R2 stated when she sat up too long</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 7</p> <p>her legs would swell up and feet went numb. R2 indicted the long wait times seemed to be worse in the afternoons between supper and 10:00 p.m., staff ran ragged and complained about how they were over worked. R2 stated once she was back in bed it became even harder to get staff to answer the call light to get help.</p> <p>During an observation on 7/26/23 at 8:30 a.m. R2 laid in bed and breakfast tray located on a bedside table, remained untouched and unreachable. At 8:56 a.m. dietary staff entered R2's room and attempted to removed breakfast tray from bedside table. R2 stated "No do not take that I have not eaten yet, the table was too far away". Dietary exited the room and R2's breakfast tray remained unreachable. At 8:57 a.m. R2 waved an unidentified staff over to her and requested the table be pulled closer to her so she could eat her breakfast. Staff assisted R2.</p> <p>R4's quarterly MDS dated 6/27/23, identified intact cognition and no behaviors. R4 required extensive assistance for bed mobility, transfers, personal hygiene, toileting, and dressing and total dependence for locomotion. R4 was always incontinent of bowel and bladder, high risk for pressure ulcers, and turn/reposition program.</p> <p>R4's care plan dated 7/28/23, identified R4 had alterations in elimination related to a history of cerebral infarction (stroke), hemiplegia (weakness on one side of the body), spinal stenosis (narrowing), and incontinent of bladder at times. R4's care plan directed staff to provide incontinence care due to bowel and bladder incontinence to have kept R4 clean, dry, and odor free daily through staff assistance and interventions. R4 received diuretics (increased</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 8 production of urine) seven out of seven days.</p> <p>R4's Kardex dated 7/28/23, identified R4 required assistance with turning every two hours and as needed, check and change and bedpan offered due to bowel and bladder incontinence. R4 required assist of two staff and a total lift to transfer.</p> <p>R4's bladder assessment dated 6/25/23, identified conditions impacted urinary continence status included cerebral vascular accident, obesity, pain, and diabetes. R4 had functional incontinence (related to inability to toilet due to cognitive or physical functioning). R4's perception of the need to void was absent and required physical assistance in toileting.</p> <p>R4's bladder urinary continence record from 7/20/23, through 7/25/23, identified:</p> <ul style="list-style-type: none"> -7/20/23, incontinent 9:52 p.m. and 5:15 p.m. -7/21/23, incontinent 12:06 a.m., 12:31 p.m., and 8:55 p.m. -7/22/23, incontinent 12:56 a.m., 1:59 p.m., and 2:38 p.m. -7/23/23, incontinent 5:25 a.m., 12:57 p.m., and 2:50 p.m. -7/24/23, incontinent 12:02 a.m., 9:32 a.m., and 9:52 p.m. -7/25/23, incontinent 1:38 a.m., 9:30 a.m., and 5:10 p.m. <p>R4's bowel assessment dated 6/25/23, identified always incontinent of bowel.</p> <p>R4's call light response time log was requested and reviewed for the date range of 7/23/23 through 7/26/23. Review of the call light response</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 9</p> <p>times for R4 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/23/23, the call light was activated at 6:31 a.m. and was responded to 21 minutes 15 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:11 a.m. and was responded to 22 minutes 22 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 9:26 a.m. and was responded to 20 minutes 08 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 10:15 a.m. and was responded to 24 minutes 31 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 2:00 p.m. and was responded to 17 minutes 31 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 6:43 a.m. and was responded to 34 minutes 07 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 2:09 p.m. and was responded to 31 minutes 21 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 2:03 p.m. and was responded to 37 minutes 28 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 5:17 p.m. and was responded to 32 minutes 0 seconds after it was activated.</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 10</p> <p>On 7/26/23, the call light was activated at 5:34 a.m. and was responded to 20 minutes 44 seconds after it was activated.</p> <p>During an interview on 7/25/23 at 10:35 a.m. R4 laid in bed and stated she had been laying in urine and stool for at least four hours now. R4 alleged staff had not been checked and changed her since around 2:00 a.m. and that happened almost every day. (see R4's bladder urinary continence record above). R4 indicated she required assistance with cares and was unable to walk. R4 stated she would like to have received morning cares earlier today but found it difficult to get assistance from staff. R4 stated the lack of staff assistance had been going on for about four months now. R4 indicated the bed sheets were generally changed every day due to wet sheets from urine, she laid there too long. R4 stated on Saturdays she hollered for staff and reminded them she needed her shower otherwise was forgotten. R4 indicated she had placed her call light on, waited up to one hour, staff came in, shut off call light, and told R4 they would be back, and did not return. R4 stated it "broke her heart" she could not get the help she needed. R4 stated she wanted to be up out of bed and in her chair daily, and staff informed her they did not have time to get her up, so she stayed in bed.</p> <p>During an observation on 7/25/23 at 10:55 a.m. R4 placed her call light on and NA-C answered in at 11:09 a.m. R4 asked to be changed and NA-C stated your sheets needed to be changed, required another staff to assist, and exited the room.</p> <p>During an observation and interview on 7/25/23 at</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 11</p> <p>11:45 a.m. (35 minutes later) NA-C and NA-D entered R4's room and applied gloves. NA-D and NA-C completed cares for R4. NA-D confirmed the brief had stool smeared on it and 50 percent saturated with urine. ND-C removed the sheets from R4's bed and placed them in a clear bag.</p> <p>R5's Significant change MDS dated 7/10/23, identified intact cognition and no behaviors. R5 required extensive assistance with personal hygiene, limited assistance with toileting, and supervision with transfers. R5 was always continent of bowel and bladder. R5's diagnoses included anxiety disorder, depression, and schizophrenia. R5 received a diuretic seven out of seven days of the look back period.</p> <p>R5's care plan dated 7/28/23, identified R5 had a ADL self-care deficit due to rheumatoid arthritis, diabetes mellitus, physical deconditioning, paranoid schizophrenia, morbid obesity, and poor eye sight. Staff were directed to assist R5 with bathing, dressing, toilet use, bed mobility, transfers assist of one in the morning and two assist after 8:00 p.m., and approach R5 warmly, positively, empathy, and understanding to bolster self-coping skills.</p> <p>R5's Kardex dated 7/28/23, identified R5 required assist of one to use toilet and complete personal hygiene.</p> <p>R5's bowel continence floor sheet dated 7/28/23 identified:</p> <p>-7/16/23 at 1:59 p.m. incontinent of bowel -7/26/23 at 9:31 p.m. incontinent of bowel</p> <p>R5's call light response time log was requested</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 12</p> <p>and reviewed for the date range of 7/5/23 through 7/12/23. Review of the call light response times for R5 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/5/23, the call light was activated at 9:48 a.m. and was responded to 25 minutes 12 seconds after it was activated.</p> <p>On 7/6/23, the call light was activated at 9:38 a.m. and was responded to 32 minutes 15 seconds after it was activated.</p> <p>On 7/7/23, the call light was activated at 9:21 a.m. and was responded to 22 minutes 05 seconds after it was activated.</p> <p>On 7/8/23, the call light was activated at 1:46 p.m. and was responded to 19 minutes 07 seconds after it was activated.</p> <p>On 7/11/23, the call light was activated at 8:07 p.m. and was responded to 17 minutes 47 seconds after it was activated.</p> <p>On 7/12/23, the call light was activated at 3:12 p.m. and was responded to 25 minutes 25 seconds after it was activated.</p> <p>During an interview and observation on 7/26/23 at 9:17 a.m., R5 sat in wheelchair with only a shirt and brief on and no shoes or slippers. R5 stated she had placed her call light on and had been waiting for assistance to wipe up the floor where she spilled her breakfast juice on her lap and then onto the floor. R5 stated staff took up to one hour to respond to the call light. R4 verified it had been hard to get help with anything especially on the evening and night shift, which seemed like staff</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 13</p> <p>did not want to come and answer it. R5 stated she had not complained about this, as she did not want to get any staff in trouble, but it made her mad and frustrated. R5 indicated she had a hard time getting fresh water, had waited up to 3 hours, and could pretty much do everything else for herself. At 9:37 a.m. (20 minutes later) NA-A knocked on door, entered the room and asked what she needed. R5 stated her wet pants needed to be picked up and NA-A stated, "oh is that all you needed?" NA-A cleaned up the floor with a towel and exited the room. R5 stated she tried to do as much for herself as possible but was unable to complete her own peri cares and it was hard to get a staff to help. R5 added, staff have told her evening cares would be completed at 9:00 p.m. but staff do not come in until 10:00 p.m. Lastly, R5 added, her anxiety level increase when call light response times take so long and this affects her mental health.</p> <p>R5's call light log on 7/26/23, the call light was activated at 9:17 a.m. and was responded to 20 minutes 59 seconds after it was activated.</p> <p>R6's Significant change MDS date 5/15/23, identified intact cognition and no behaviors. R6 required extensive assistance with bed mobility, dressing, personal hygiene, and toileting and total dependence on staff for transfers. R6 was frequently incontinent of bladder and occasionally incontinent of bowel. R6's diagnoses included anxiety and manic depression.</p> <p>R6's care plan dated 7/28/23, identified R6 had limited physical mobility related to muscle weakness, deformities of the foot, essential tremors, morbid obesity, chronic pain, fibromyalgia, and contractures of the left hand.</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 14</p> <p>R6's care plan directed staff to transfer R6 full body lift and assistance of two staff and routinely turn an reposition at least every two hours.</p> <p>R6's Kardex dated 7/28/23, identified, R6 needed encouragement to off load and/or change positions at least every 2 hours and incontinent of bladder at times.</p> <p>R6's call light response time log was requested and reviewed for the date range of 7/21/23 through 7/24/23. Review of the call light response times for R6 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/21/23, the call light was activated at 6:33 p.m. and was responded to 55 minutes 25 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 8:02 a.m. and was responded to 56 minutes 22 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 6:35 p.m. and was responded to 49 minutes 33 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 9:09 p.m. and was responded to 31 minutes 33 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:57 a.m. and was responded to 38 minutes 22 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 9:41 a.m. and was responded to 25 minutes 54 seconds after it was activated.</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 15</p> <p>On 7/23/23, the call light was activated at 6:17 p.m. and was responded to 38 minutes 25 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 7:41 a.m. and was responded to 1 hour 13 minutes 7 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 5:58 p.m. and was responded to 1 hour 51 minutes 45 seconds after it was activated.</p> <p>During an interview/observation on 7/25/23 at 12:40 p.m. R6's call light was on. Activity staff walked down hallway past R6's room, entered a neighbor's room, and did not answer R6's call light. R6 stated she had placed call light on a bit ago, NA-A came in and turned call light off, informed R6 she would look for another staff to help her. R6 stated she had waited up to approximately 30 to 45 minutes, no staff came, placed call light on again. R6 stated another staff came and answered her call light and informed her NA-A did not say anything about you needed help. R6 confirmed she had urine accidents, it had been a while, she tried to hold it until staff could get here to help her. R6 stated staff got upset when she would ask for many small things usually the evening and nighttime shifts. R6 stated she has been told by staff they have other people to take care of, get to the point, and are in a rush to leave her room. R6 stated she understood they are busy but would it only took a few minutes to help her and they made her feel like she was a burden to them.</p> <p>R7's Admission MDS dated 7/12/23, identified intact cognition and no behaviors. R7 required</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 16</p> <p>extensive assistance with bed mobility, dressing, toilet use, personal hygiene and total dependence with transfers. R 7 was frequently incontinent of bowel and bladder with a history of urinary tract infections.</p> <p>R7's care plan dated 7/18/23, identified R7 had an ADL self-care deficit related to osteoporosis pain, muscle spasms, weakness, and deconditioning. Staff were instructed to provide assist of two with sit to stand lift, keep pressure off of left lower heel/extremity, and may use bedside commode for toileting.</p> <p>R7's call light response time log was requested and reviewed for the date range of 7/16/23 through 7/21/23. Review of the call light response times for R7 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/16/23, the call light was activated at 7:33 a.m. and was responded to 22 minutes 41 seconds after it was activated.</p> <p>On 7/17/23, the call light was activated at 11:13 a.m. and was responded to 17 minutes 45 seconds after it was activated.</p> <p>On 7/18/23, the call light was activated at 3:10 p.m. and was responded to 19 minutes 47 seconds after it was activated.</p> <p>On 7/19/23, the call light was activated at 8:12 a.m. and was responded to 19 minutes 12 seconds after it was activated.</p> <p>On 7/19/23, the call light was activated at 9:30 p.m. and was responded to 22 minutes 08</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 17 seconds after it was activated.</p> <p>On 7/21/23, the call light was activated at 4:33 a.m. and was responded to 17 minutes 39 seconds after it was activated.</p> <p>Interview on 7/26/23 at 1:20 p.m., R7 laid in bed on her back. R7 stated the call light wait times get to be long in the morning because they are short staffed. R7 stated two weeks ago, she placed her call light on early in the morning around just after 9:00 a.m. and took staff over 20 minutes later staff came in, turned off call light, informed her they would be right back, and staff returned much later. R7 stated she laid in bed from 7:00 a.m. to 10:30 a.m. incontinent of urine, and wanted to be up by at least 9:00 a.m. R7 stated she has to wait up to two hours to get laid down and staff tell me they will help, but do not come back. R7 stated she felt so helpless and unable to get help when needed.</p> <p>On 7/12/23, R7's call light was activated at 9:12 a.m. and was responded to 25 minutes 33 seconds after it was activated.</p> <p>Review of R7's urinary continence dated 7/12/23 at 10:37 a.m. R7 was incontinent of urine.</p> <p>R8's Significant change MDS dated 6/27/23, identified intact cognition and no behaviors. R8 required extensive assistance with bed mobility, dressing, and toilet use and limited assistance with personal hygiene and transfers. R8 was occasionally incontinent of bladder and always continent of bowel. R7 received a diuretic 7 out of 7 days during the look back period.</p> <p>R8's care plan dated 7/28/23, identified an ADL</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 18</p> <p>self-care deficit related to chronic right shoulder pain and obesity. Staff were instructed to provide assistance with peri cares to help avoid further urinary tract infections and check and change as needed due to incontinence.</p> <p>R8's Kardex identified required assistance of one for bathing and assistance with lower body cleansing.</p> <p>R8's call light response time log was requested and reviewed for the date range of 6/29/23 through 7/7/23. Review of the call light response times for R8 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 6/29/23, the call light was activated at 6:14 a.m. and was responded to 40 minutes 2 seconds after it was activated.</p> <p>On 6/29/23, the call light was activated at 7:39 a.m. and was responded to 37 minutes 12 seconds after it was activated.</p> <p>On 7/1/23, the call light was activated at 6:13 a.m. and was responded to 30 minutes 19 seconds after it was activated.</p> <p>On 7/2/23, the call light was activated at 8:50 a.m. and was responded to 21 minutes 01 seconds after it was activated.</p> <p>On 7/5/23, the call light was activated at 8:40 a.m. and was responded to 15 minutes 10 seconds after it was activated.</p> <p>On 7/6/23, the call light was activated at 7:32 a.m. and was responded to 1 hour 14 minutes 39</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 19 seconds after it was activated.</p> <p>On 7/7/23, the call light was activated at 7:40 a.m. and was responded to 20 minutes 12 seconds after it was activated.</p> <p>During an interview on 7/26/23 at 12:51 p.m. R8 stated they are short staffed quite often, especially on weekends. R8 stated this past Saturday on 7/22/23, staff called in sick and there was (verified by schedule)only one staff on the floor for about two hours. R8 indicated she did had not received her scheduled shower that day. R8 stated last evening on 7/25/23, NA-A arrived in her room and instructed her to turn the call light off. R8 stated she asked NA-A for a gown and assistance with evening cares, NA-A left the room and did not return. R8 stated she placed call light on again that evening but no one came so R8 turned off light, and fell asleep in her clothing. R8 stated she does not feel the facility has enough staff to meet our needs. R8 stated earlier this month, used call light early in the morning, and waited up to over and hour for assistance. R8 also stated on 7/26/23, she had been yelled at by an NA at 6:30 a.m. when she placed her call light on before 6:30 a.m. and was told to not to use the call light prior to 6:30 a.m., staff were in report. R8 stated she waited until closer to 8:00 a.m. placed the call light on again and received assistance. R8 stated had not told any one because it would not do any good. R8 stated she would have told the social worker but had previously talked to her, and had not received much help. R8 indicated she does usually attended the resident counsel meeting, but was in too much pain to attend the last one. R8 had brought up concerns during a previous resident counsel meeting and nothing was really resolved.</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 20</p> <p>Review of facility staff schedule day shift on 7/22/23 identified: day shift 6:00 a.m. to 2:30 p.m. one float NA and 7:00 a.m. to 2:30 p.m. one NA, and one nurse. (short NA from 6:00 a.m. to 7:00 a.m. and 9:30 a.m. to 10:30 a.m. and short two NA's from 10:30 a.m. to 2:30 p.m.) one nurse 6:00 a.m. to 7:15 a.m. two nurses from 7:15 a.m. to 8:30 a.m., three nurses 8:30 a.m. to 10:30 a.m., two nurses 10:30 a.m. to 2:30 p.m. (short nurse from 6:00 a.m. to 7:15 a.m.)</p> <p>Review of the call light times for R8 revealed on 7/26/23, her call light was activated at 6:27 a.m. and not again until 7:50 a.m.:</p> <p>On 7/26/23, the call light was activated at 6:27 a.m. and was responded to 13 minutes 3 seconds after it was activated.</p> <p>On 7/26/23, the call light was activated AT 7:50 a.m. and was responded to 41 seconds after it was activated.</p> <p>R8's shower/bathing record indicated no shower/bath was documented as completed on 7/22/23.</p> <p>During an interview on 7/26/23 at 2:07 p.m. NA-A stated did not assist R8 with evening cares last night on 7/25/23 and did not recall answering R8's call light. NA-A stated R8 does not need help with cares anyway.</p> <p>Review of the call light times for R8 on 7/25/23, revealed her call light was activated: -at 7:41 p.m. and responded to 8 minutes 2</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 21 seconds</p> <p>-at 7:53 p.m. and responded to 18 minutes 19 seconds</p> <p>-at 8:11 p.m. and responded to 5 minutes 10 seconds</p> <p>R8's call light was not activated again on 7/25/23, until 2:08 a.m.</p> <p>R11's Significant change MDS dated 7/26/23, identified intact cognition and no behaviors. R11 required extensive assistance for bed mobility, transfers, personal hygiene, toileting, dressing, and locomotion. R11 was occasionally incontinent of bladder and frequently incontinent of bowel with a history of bladder infections.</p> <p>R11's care plan dated 7/28/23, identified R11 had an activities of daily living (ADL) self-care deficit related to contractures of bilateral hands, altered mental status, low back pain, and weakness. R11 required assist of two staff for toilet us. Staff were directed to offer toileting every two hours.</p> <p>R11's Kardex dated 7/28/23, identified R11 required assist of two and EZ stand to transfer and offer toileting every two hours and document refusals.</p> <p>R11's Bladder evaluation dated 7/26/23, identified frequently incontinent due to memory problems, impaired decision making, required physical assistance in toileting, obesity, and diabetes. R11's perception of need to void was diminished.</p> <p>R11's call light response time log was requested and reviewed for the date range of 7/23/23</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 22 through 7/25/23. Review of the call light response times for R11 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/22/23, the call light was activated at 9:11 p.m. and was responded to 29 minutes 05 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 7:21 a.m. and was responded to 31 minutes 15 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 1:25 p.m. and was responded to 20 minutes 11 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 10:59 p.m. and was responded to 20 minutes 31 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 10:59 p.m. and was responded to 20 minutes 31 seconds after it was activated.</p> <p>On 7/26/23, the call light was activated at 8:48 a.m. and was responded to 30 minutes 41 seconds after it was activated.</p> <p>During an interview on 7/26/23 at 1:39 p.m. R11 stated placed call light on this morning around 8:45 a.m. and had taken staff over 30 minutes for the staff to respond. R11 also stated call light did not seem to work at times with how long she had waited for staff to answer it. R11 stated she required assistance of staff and a stand lift to get up to the commode, waited too long, and resulted in urine and stool accidents.. R11 stated when she went in her pants did not feel very good about</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 23</p> <p>it and was embarrassed. R11 stated she had placed the call light on at about 1:15 p.m., and now it is 1:45 p.m., with no staff having answered it yet. R11 indicated she tried to hold her urine as long as she could, currently had urinary tract infection, and this had become difficult to do. R11 requested surveyor please let staff know she needed help to the bathroom, not sure how much longer she could hold it before she had an accident in her pants. Interview ended at 1:45 p.m.</p> <p>Observation on 7/26/23 at 1:52 p.m. two call lights R6 and R11 had been on since 1:45 p.m. located in the same hallway. NA-A walked down this hallway to the room next to R11's room carrying clean linen, walked into the neighbor's room and closed the door. Seven minutes later at 1:55 p.m. NA-A walked out of that room, did not answer R6's or R11's call lights and walked down the hallway to the nurse's station slowly.</p> <p>Observation on 7/26/23 at 1:55 p.m. NA-B walked into R11's room, shut off call light, said she would find someone to help her, and exited the room. NA-B then walked into R6's room, shut off call light, said she would find someone to help her and be back, and exited the room. NA-B walked down hallway to the nurse's station and did not return to R11's or R6's rooms during this observation.</p> <p>Observation on 7/26/23 at 2:01 p.m. NA-G walked down hallway and into R11's room and stated you need to go to the bathroom? R11 stated yes, really bad. NA-G exited the room waked down hallway and returned to R11's room at 2:03 p.m. NA-G placed gloved hands and informed R11 they had to wait for assistance of</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 24</p> <p>another staff. At 2:10 p.m. NA-A entered R11's room, placed gloves on hands, raised resident up off wheelchair with the sit to stand lift, and lowered her onto the commode. NA-G verified R11's brief was dry, gave R11 a call light, exited the room. NA-A and NA-G did not enter R6's room across the hallway and walked towards the nurse's station.</p> <p>During an interview on 7/25/23 at 1:00 p.m. NA-C explained day shift received report on all residents, answered call lights, completed cares first on the residents required assistance of two, then assisted residents who required assistance of one to get up, and lastly assisted the other residents when help was needed. NA-C indicated staff were not assigned to specific residents and did not get residents up by time preference. NA-C stated there was a cheat sheet listed of all residents located at the nurse's station. NA-C stated all staff were required to cross names off as cares were completed on each resident. NA-C indicated all residents should have been checked and changed every two hours. NA-C stated some residents placed their call light on when assistance was needed for toileting however, resident unable to should have been checked and changed every two to two and half hours. NA-C stated staff were expected to answer call lights within two to three minutes.</p> <p>During an interview on 7/25/23 at 2:13 p.m. NA-A stated day shift received report on all residents, completed cares on residents required assist of two first and another staff completed showers. NA-A indicated staff were not assigned to specific residents.</p> <p>During an interview on 7/26/23 at 2:34 p.m., NA-E</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 25</p> <p>stated they needed more staff to complete all tasks. NA-E stated they had answered one residents call light 15 times already this shift. NA-E indicated there were times when a resident only needed something simple like a television channel changed or asked to be covered up. NA-E confirmed approximately one half of the residents were incontinent of urine by the time they got to them today. NA-E confirmed floor nurses did not answer call lights but trained medication aids (TMA) answered call lights occasionally.</p> <p>During a follow up interview on 7/27/23 at 9:51 a.m., NA-E indicated it was hard to keep up with meeting the resident's basic needs such as toileting and bathes when not enough staff were scheduled. NA-E verified only two staff worked today along with one person training. NA-E also indicated occasionally a NA floated between the two floors and helped out.</p> <p>During an interview on 7/28/23 at 12:56 p.m., assistant director of nursing (ADON) stated they were not aware of any concerns staff regarding staffing and expected the staffing scheduler to have filled the schedule. ADON also stated call lights averaged much less than 10 minutes and audits would have been completed by the social worker. ADON expected staff to prioritize how quickly they answered the call lights and go to the residents first with safety issues. ADON expected staff to take care of the residents and was unable to place a length of time on the expectation regarding answering call lights.</p> <p>During an interview on 7/28/23 at 1:26 p.m. social worker (SW) stated staff and residents had complained about long call light times. SW</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 26</p> <p>indicated the entire second floor was looked at for one week regarding long call wait times and majority of the call lights were under 15 minutes, some longer, and one was 30 minutes. SW stated these results were shared with DON and ADON and talked about the findings, no notes were taken during this audit or meeting. SW stated they had planned a weekly call light audit for the next three weeks, so the long call light wait times and any trends or specific rooms could be addressed accordingly. SW stated up to a 30 minute wait time would be the maximum time a resident should have to wait for the call light to be answered.</p> <p>During an interview on 7/28/23 at 1:44 p.m. LPN-B stated there were not sufficient staff to meet the needs of resident and provide safe care especially when residents were first admitted. LPN-B stated facility had a high turnover rate of residents with a high acuity. LPN-B stated frequently only two NA's would be scheduled to care for over 30 residents and needs such as toileting and basic cares were not being met.</p> <p>During an interview on 7/28/23 at 1:52 p.m., NA-F stated staffing was an issue, adding two NA's were not enough to care for 33 residents. NA-F indicated they felt rushed through all cares and was unable to take the time needed to care for residents properly. NA-F stated our equipment such as lifts do not work properly, batteries are worn out, and residents are up in the air longer than they should be. NA-F verified approximately 75% of the residents were already incontinent prior to getting assistance from staff due to the length of time it took to get to each one and that should not be happening. NA-F stated most of the time when the facility is short staffed it is due to</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	<p>Continued From page 27</p> <p>call ins. NA-F indicated they work three double shifts a week due to shortage of staff. NA-F also stated resident wait times are longer than they should be due to staff turning off the call light, informed resident they will return with help, then get busy, and forget to go back to assist them.</p> <p>During an interview on 7/28/23 at 4:15 p.m. director of nursing (DON) stated expected all staff to answer call lights and included administration, maintenance, and dietary. DON stated when non-direct care employee answered a call light they were expected to find help to meet the resident's needs. DON indicated expectations related to call light response time varied from resident to resident. DON confirmed audits had been completed before and some residents had said an hour response time was fine, others said 10 minutes, 20 minutes, and 30 minutes. DON verified she had reviewed a multitude of call light audits in the past, they were really good response times, and then there were some that had longer during high call times such as before and after meals and at bedtime DON stated call light times varied and depended on the resident. DON also stated personally, call light response time should be within 10 minutes but varied with each resident and their needs</p> <p>Resident Council Meeting Minutes dated 7/19/23, identified eight residents attended (included R1, R2, R5, R6). Current situation/concern call lights not being answered in a timely manner. Need a faster response time. Nursing and social services would be expected to help resolve this current concern.</p> <p>Facility policy titled Call Light Use and Response dated 7/18/23, identified staff were expected to</p>	F 550		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	Continued From page 28 respond promptly to resident's call for assistance. All facility personnel must be aware of call lights at all times, answer call lights promptly whether or not the staff person was assigned to the resident or not. Answer all call lights in a prompt, calm, courteous manner; turn off call light as soon as you enter the room and attend to the resident's needs. Consider a quality assurance and assessment program to check the call light system at regular intervals.	F 550		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		8/28/23

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 29 continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist residents with timely bladder incontinence care for 2 of 8 residents (R2, R4) reviewed who were frequently incontinent of bladder despite having/needing assessed toileting schedules and requesting toileting assistance through the call light system.</p> <p>Findings include:</p> <p>R2's significant change MDS dated 6/9/23 identified intact cognition and no behaviors. R2 had diagnoses of anxiety and congestive heart failure (CHF). R2 required extensive assistance of one for bed mobility, personal hygiene, and dressing and extensive assistance of two for transfers and toilet use. R1 was frequently incontinent of bowel and bladder. R1 received diuretics (increased production of urine) seven out of seven days during the look back period.</p> <p>R2's care plan date 7/28/23, identified staff were directed to reposition resident at least every two hours per tolerance and schedule. (No schedule identified)</p> <p>R2's Kardex dated 7/28/23, identified R2 required assist of one staff for toileting and incontinent of</p>	F 690	<p>F690 The facility failed to assist residents with timely bladder incontinence care for 2 of 8 residents (R2, R4) reviewed who were frequently incontinent of bladder despite having/needing assessed toileting schedules and requesting toileting assistance through the call light system.</p> <ol style="list-style-type: none"> 1. Bowel and bladder assessments were completed for R2 and R4 on 8/17/23 to ensure appropriate toileting plans are in place and care plans updated as needed. 2. Every incontinent resident in the facility that requires staff assist with toileting needs has the potential of being affected by this deficient practice. 3. Nursing staff educated on toileting policy. Re-organization of CNA tasks via resident grouping to improve accountability. 4. Audits developed to be completed and audited by the DON, or designee, 3x weekly for 4 weeks, then weekly for 2 months and will be presented at QAPI for review. 5. This deficiency will be corrected 8/28/23 	

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 30</p> <p>bowel and bladder at times. (No toileting schedule identified)</p> <p>R2's bladder assessment completed on 7/18/23, identified R2 always incontinent of urine and voiding pattern after breakfast, lunch, supper, and at bedtime. R2 had stress incontinence (urine incontinence with physical movement caused leaking of urine) and urgency (unintentional loss of urine). Toileting trial or current program (scheduled toileting, prompted voiding, or bladder training) being used to manage R2's urinary continence, not assessed.</p> <p>R2's bladder urinary continence record from 7/20/23, through 7/25/23, identified:</p> <p>-7/20/23 incontinent 2:27 a.m., 10:00 a.m., and 3:03 p.m. -7/21/23 incontinent 12:11 a.m. and 5:46 p.m. -7/22/23 incontinent 1:39 p.m., 1:59 p.m., and 2:46 p.m. -7/23/23 continent 5:31 a.m. and incontinent 10:22 a.m. and 2:37 p.m. -7/24/23 incontinent 12:04 a.m., 9:30 a.m., and 9:59 p.m. -7/25/23 incontinent 1:43 a.m., 9:28 a.m., and 5:42 p.m.</p> <p>R2's call light response time log was requested and reviewed for the date range of 7/22/23 through 7/25/23. Review of the call light response times for R2 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/22/23, the call light was activated at 5:48 p.m. and was responded to 22 minutes 11 seconds after it was activated.</p>	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 31</p> <p>On 7/22/23, the call light was activated at 9:47 p.m. and was responded to 29 minutes 17 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:15 a.m. and was responded to 22 minutes 0 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:58 a.m.. and was responded to 26 minutes 01 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 2:06 p.m. and was responded to 20 minutes 37 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 6:09 p.m. and was responded to 25 minutes 39 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:20 p.m. and was responded to 31 minutes 10 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 6:09 p.m. and was responded to 30 minutes 27 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 7:24 p.m. and was responded to 26 minutes 55 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 8:38 p.m. and was responded to 30 minutes 28 seconds after it was activated.</p> <p>During an interview on 7/25/23 at 3:15 p.m. R2 stated staff came into their room, turned off call</p>	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 32</p> <p>light and told me they would be right back, and no one came back. R2 indicted she then turned the call light on again 30 minutes later and staff repeated the same process. R2 verified it would take up to three hours to put her back to bed or get her up at times. R2 stated she knew staff were busy but counted on their word when they told her they would be right back and after a while they need to come back and take care of those they forgot. R2 also stated she felt like she had been forgotten and indicated she had complained to nurses, NA's and the social worker. R2 stated she hesitated to put on the call light when staff were so busy, staff made her feel like she made it harder on them when she used the call light, and she became frustrated. R2 identified they could do better but hard to do when short staffed frequently. R2 indicted the long wait times seemed to be worse in the afternoons between supper and 10:00 p.m., staff ran ragged and complained about how they were over worked. R2 stated once she was back in bed it became even harder to get staff to answer the call light to get help.</p> <p>During an observation on 7/25/23 at 9:20 a.m., located in R2's bathroom noted a large orange bedpan positioned on top of the high rise toilet seat with urine, large formed dark brown stool and urine saturated toilet paper at 9:20 am.</p> <p>During an observation on 7/25/23 at 11:45 a.m., NA-D and NA-C completed cares on R2's roommate R4, NA-D went into bathroom and removed gloves, washed hands at the sink with soap and water, and exited bathroom. Bed pan remained in bathroom on top of the high rise toilet seat with stool, urine and saturated toilet paper in it. Stool and urine odor noted in bathroom.</p>	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 33</p> <p>During an observation on 7/25/23 at 11:50 a.m. housekeeping (H)-A entered R2's room, swept and washed the floor and exited the room. Bed pan remained in bathroom on top of the high rise toilet seat with stool, urine and saturated toilet paper. Stool and urine odor noted in bathroom.</p> <p>During an observation on 7/25/23 at 1:00 p.m. bed pan remained in bathroom on high rise toilet seat untouched.</p> <p>During an observation on 7/25/23 at 1:25 p.m. NA-C entered R2's room, asked NA-D needed assistance with roommate, looked in bathroom, and exited the room. Bed pan remained in bathroom on high rise toilet seat with stool, urine, and saturated toilet paper.</p> <p>During an interview on 7/25/23 at 2:15 p.m. H-A stated bathroom was not cleaned this morning, there was S*** in the bedpan and should have been emptied by nursing staff. H-A verified a big chunk of dark poop was in there, did not tell nursing staff, assumed they would have come back and dumped it. H-A also verified the bathroom smelt like stool and urine.</p> <p>During observations on 7/25/23:</p> <ul style="list-style-type: none"> -at 10:00 am R2 sat in wheelchair at a table in television/ lounge area and worked on crafts with another resident. -at 12:00 pm R2 sat in wheelchair at a table in dining room and fed herself lunch. -at 12:30 pm R2 sat in wheelchair in television/lounge area at a table by herself and worked on crafts. 	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 34</p> <p>-at 1:00 pm R2 sat in wheelchair in television/lounge area position unchanged and worked on crafts.</p> <p>During an observation on 7/26/23 at 1:17 p.m. R2's room call light was noted to be on.</p> <p>During an observation on 7/26/23 at 1:50 p.m. R2's room call light was noted to be on (over 30 minutes later). At 2:00 p.m. two nursing staff sat at nurse's station.</p> <p>During an Intrview on 7/25/23, at 11:45 a.m. NA-D stated staff are not assigned to any specific residents on the day shift and are chosen randomly.</p> <p>During an interview on 7/25/23 at 1:00 p.m. NA-C stated explained when she arrived to work for the day shift received report on all residents, answered call lights, completed cares first on the residents required assistance of two to get them up, then assisted residents required assistance of one to get up, and lastly assisted the other residents when help was needed. NA-C stated a cheat sheet listed all residents located at the nurse's station. NA-C stated all staff were required to cross names off as cares were completed on each resident. NA-C indicated all residents should have been checked and changed every two hours. NA-C stated some residents placed their call light on when assistance was needed for toileting however, resident unable to should have been checked and changed every two to two and half hours. NA-C stated staff were expected to answer call lights within two to three minutes. NA-C verified she had completed cares on R2 this morning, used bedpan due to felt weak and unable to stand safely. NA-C indicated along</p>	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 35</p> <p>with NA-A removed R2 from bedpan after she had used it. NA-C also stated R2 had not gone to the bathroom since before 10:40 a.m. today and had sat at the circle table in lounge and worked on diamond art. NA-C stated R2 was incontinent of bowel and bladder at times and able to tell staff when she needed to go.</p> <p>During an interview on 7/25/23 at 2:13 p.m. NA-A stated on day shift received report on all residents, completed cares on residents required assist of two first and another staff completed showers. NA-A verified she had assisted NA-C with R2's toileting this morning. NA-A indicated R2 had call light on. NA-A stated NA-C removed R2 from bedpan and placed it in the bathroom with stool and urine in it.</p> <p>R4's quarterly MDS dated 6/27/23, identified intact cognition and no behaviors. R4 required extensive assistance for bed mobility, transfers, personal hygiene, toileting, and dressing and total dependence for locomotion. R4 was always incontinent of bowel and bladder, high risk for pressure ulcers, and turning/repositioning program. R4 received diuretics (increased production of urine) seven out of seven days.</p> <p>R4's care plan dated 7/28/23, identified R4 had alterations in elimination related to a history of cerebral infarction (stroke), hemiplegia (weakness on one side of the body), spinal stenosis (narrowing), and incontinent of bladder at times. R4's care plan directed staff to provide incontinence care due to bowel and bladder incontinence to have kept R4 clean, dry, and odor free daily through staff assistance and interventions.</p>	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 36</p> <p>R4's Kardex dated 7/28/23, identified R4 required assistance with turning every two hours and as needed, check and change and bedpan offered due to bowel and bladder incontinence. R4 wore incontinent brief due to bowel and bladder incontinence. R4 required assist of two staff and a total lift to transfer.</p> <p>R4's bladder assessment dated 6/25/23, identified conditions impacted urinary continence included cerebral vascular accident, obesity, pain, and diabetes. R4 had functional incontinence (related to inability to toilet due to cognitive or physical functioning) and always incontinent. R4's perception of the need to void was absent and required physical assistance in toileting to impact ability to maintain or attain continence. Toileting trial or current program being used to manage R4's urinary continence, not assessed.</p> <p>R4's bladder urinary continence record from 7/18/23, through 7/25/23, identified:</p> <ul style="list-style-type: none"> -7/18/23, incontinent 2:08 a.m. and 9:28 p.m. and continent 1:31 p.m. -7/19/23 incontinent 1:17 a.m., 12:49 p.m., 9:00 p.m., and 11:04 p.m. -7/20/23, incontinent 9:52 p.m. and 5:15 p.m. -7/21/23, incontinent 12:06 a.m., 12:31 p.m., and 8:55 p.m. -7/22/23, incontinent 12:56 a.m., 1:59 p.m., and 2:38 p.m. -7/23/23, incontinent 5:25 a.m., 12:57 p.m., and 2:50 p.m. -7/24/23, incontinent 12:02 a.m., 9:32 a.m., and 9:52 p.m. -7/25/23, incontinent 1:38 a.m., 9:30 a.m., and 5:10 p.m. 	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 37</p> <p>R4's call light response time log was requested and reviewed for the date range of 7/22/23 through 7/25/23. Review of the call light response times for R2 revealed her call light was not responded to in a timely manner on the following dates:</p> <p>On 7/22/23, the call light was activated at 5:48 p.m. and was responded to 22 minutes 11 seconds after it was activated.</p> <p>On 7/22/23, the call light was activated at 9:47 p.m. and was responded to 29 minutes 17 seconds after it was activated.</p> <p>On 7/23/23, the call light was activated at 8:15 a.m. and was responded to 22 minutes 0 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:58 a.m.. and was responded to 26 minutes 01 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 2:06 p.m. and was responded to 20 minutes 37 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 6:09 p.m. and was responded to 25 minutes 39 seconds after it was activated.</p> <p>On 7/24/23, the call light was activated at 11:20 p.m. and was responded to 31 minutes 10 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 6:09 p.m. and was responded to 30 minutes 27 seconds after it was activated.</p>	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 38</p> <p>On 7/25/23, the call light was activated at 7:24 p.m. and was responded to 26 minutes 55 seconds after it was activated.</p> <p>On 7/25/23, the call light was activated at 8:38 p.m. and was responded to 30 minutes 28 seconds after it was activated.</p> <p>During an interview on 7/25/23 at 10:35 a.m. R4 laid in bed and alleged she had been laying in urine and stool for at least four hours now (See R4's bladder urinary continence record). R4 verified staff had not been checked and changed her since around 2:00 a.m. and that happened almost every day. R4 indicated she required assistance with cares and was unable to walk. R4 stated she would like to have received morning cares earlier today but found it difficult to get assistance from staff. R4 stated the lack of staff assistance had been going on for about four months now. R4 indicated the bed sheets were generally changed every day due to wet sheets from urine, she laid there too long. R4 stated on Saturdays she hollered for staff and reminded them she needed her shower otherwise was forgotten. R4 indicated she had placed her call light on, waited up to one hour, staff came in, shut off call light, and told R4 they would be back, and did not return. R4 stated it "broke her heart" she could not get the help she needed. R4 stated she wanted to be up out of bed and in her chair daily, and staff informed her they did not have time to get her up, so she stayed in bed.</p> <p>During an observation on 7/25/23 at 10:55 a.m. R4 placed her call light on and NA-C answered in at 11:09 a.m. (14 minutes). R4 asked to be changed and NA-C stated we needed to change your sheets also, required another staff to assist,</p>	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 39 and exited the room at 11:10 a.m.</p> <p>During an observation and interview on 7/25/23 at 11:45 a.m., (35 minutes later) NA-C and NA-D entered R4's room and applied gloves. NA-D and NA-C completed cares for R4. NA-D confirmed the brief had stool smeared on it and 50 percent saturated with urine. ND-C removed the sheets from R4's bed and placed them in a clear bag.</p> <p>During an interview on 7/25/23 at 3:15 p.m. LPN-A stated staffing was ok on the day and night shifts but evening shift struggled to get all cares and charting completed by the end of their shift. LPN-A confirmed agency staff was filling in tonight due to being short three staff.</p> <p>During an interview on 7/26/23 at 2:34 p.m., NA-E stated they needed more staff to complete all tasks. NA-E confirmed approximately one half of the residents were incontinent of urine by the time they got to them today. NA-E confirmed floor nurses did not answer call lights but trained medication aids (TMA) answered call lights occasionally.</p> <p>During a follow up interview on 7/27/23 at 9:51 a.m., NA-E indicated it was hard to keep up with meeting the resident's basic needs such as toileting and bathes when not enough staff were scheduled. NA-E verified only two staff worked today along with one person training. NA-E also indicated occasionally a NA floated between the two floors and helped out.</p> <p>During an interview on 7/28/23 at 12:16 p.m. staffing coordinator (SC) NA's came to her approximately twice a month and informed her there was too much work and too hard of work</p>	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	<p>Continued From page 40</p> <p>even when fully staffed. SC stated every other weekend the facility worked short staffed, usually short one NA. SC stated she was unaware as to what the staff cannot get done on their shifts.</p> <p>During an interview on 7/28/23 at 12:56 p.m., assistant director of nursing (ADON) expected staff to prioritize how quickly they answered the call lights and go to the residents first with safety issues. ADON expected staff to take care of the residents and was unable to place a length of time on the expectation regarding answering call lights.</p> <p>During an interview on 7/28/23 at 1:44 p.m. LPN-B stated there were not sufficient staff to meet the needs of resident and provide safe care especially when residents were first admitted. LPN-B stated facility had a high turnover rate of residents with a high acuity. LPN-B stated frequently only two NA's would be scheduled to care for over 30 residents and needs such as toileting and basic cares were not being met.</p> <p>During an interview on 7/28/23 at 1:52 p.m., NA-F stated staffing was an issue, adding two NA's were not enough to care for 33 residents. NA-F indicated they felt rushed through all cares and was unable to take the time needed to care for residents properly. NA-F stated our equipment such as lifts do not work properly, batteries are worn out, and residents are up in the air longer than they should be. NA-F verified approximately 75% of the residents were already incontinent prior to getting assistance from staff due to the length of time it took to get to each one and that should not be happening.</p> <p>Review of facility schedule from 7/17/23 through</p>	F 690		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 690	Continued From page 41 7/22/23 there was never a day that the facility was not short at least one nurse or nurse aid or combination of both positions each day during the time period. See F0725 Sufficient Staffing	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		8/28/23

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 42</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and document review the facility failed to provide sufficient staffing to meet the care needs of the residents in a timely manner for 8 of 10 residents (R1, R2, R4, R5, R6, R7, R8, R11) reviewed for staffing.</p> <p>Findings include:</p> <p>R1's five-day assessment Minimum Data Set (MDS) dated 6/27/23, identified moderately impaired cognition with no behaviors. R1 required extensive assistance of for bed mobility, transfers, personal hygiene, toileting, and dressing and independent in wheelchair for locomotion. R1 was always continent of bladder and occasionally incontinent of bowel. R1 received diuretics (increased production of urine) seven days out of seven days of the look back period.</p> <p>R1's care plan dated 7/28/23, identified R1 required extensive assist of two staff with the sit to stand lift for transfers.</p> <p>R1's Kardex dated 7/28/23, identified R1 required extensive assistance of one with toilet use and extensive assistance of two with the sit to stand lift. Staff were instructed to turn and reposition R1 every two hours.</p> <p>During an observation on 7/28/23 at 12:47 p.m. R1 wheeled himself around in wheelchair approached surveyor in the hallway by the entry</p>	F 725	<p>F725</p> <p>The facility failed to provide sufficient staffing to meet the care needs of the residents in a timely manner for 8 of 10 residents (R1, R2, R4, R5, R6, R7, R8, R11) reviewed for staffing.</p> <ol style="list-style-type: none"> 1. Unable to go back to specific dates/times to resolve past concerns and wait times. Chart review for all affected residents shows no lasting negative affect noted. Social Worker met with affected residents and no lasting negative psychosocial affect noted. 2. Every resident in the facility has the potential of being affected by this deficient practice. 3. Acuity, resident needs and census are reviewed on a daily basis by the Interdisciplinary Team in morning stand up and changes implemented as deemed appropriate on an ongoing basis to ensure continued compliance with staffing needs. 4. Scheduler, or designee, is responsible for scheduling at appropriate levels. Audits to be completed and audited by scheduler, or designee, 3x week for 4 weeks, then weekly x2 months and will be presented at QAPI for review. The need for potential change in the staffing patterns will be reviewed ongoing by the Interdisciplinary Team in morning stand up and changes implemented as deemed 	

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 43</p> <p>way. R1 stated tried to find someone to help him to the bathroom, but seemed liked when he looked, they all disappeared. R1 then approached an unidentified staff who was pushing a mechanical lift machine down the hallway. R1 asked the staff if he could get help going to the bathroom. The staff stated my partner was on break and there were only two staff on the floor working right now so R1 would have to wait at least another 20 minutes before he could be helped and walked away. R1 pushed himself over to the television room and said out loud, "geez hope I can wait that long."</p> <p>During an interview on 7/15/23 at 2:15 p.m. R1 stated they were a morning person and wanted to be up by 6:30 a.m., usually placed call light on but the staff were slow to answer, and sometimes had to wait up to 20 minutes in the morning to get up. R1 verified staff came in, shut call light off, said they would come back, and had taken a while before they returned. R1 also stated there were times when it had taken much longer to get help, up to an hour, and usually fell asleep waiting for them to help.</p> <p>R2's significant change MDS dated 6/9/23 identified intact cognition and no behaviors. R2 had diagnoses of anxiety and congestive heart failure (CHF). R2 required extensive assistance of one for bed mobility, personal hygiene, and dressing and extensive assistance of two for transfers and toilet use. R1 was frequently incontinent of bowel and bladder. R1 received diuretics (increased production of urine) seven out of seven days during the look back period.</p> <p>R2's care plan date 7/28/23, identified staff were directed to reposition resident at least every two</p>	F 725	<p>appropriate on an ongoing basis to ensure continued compliance.</p> <p>5. This deficiency will be corrected 8/28/23</p>	

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 44 hours per tolerance and schedule.</p> <p>R2's Kardex dated 7/28/23, identified R2 required assist of one staff for toileting and incontinent of bowel and bladder at times.</p> <p>R2's bladder assessment completed on 7/18/23, identified R2 always incontinent of urine and voiding pattern after breakfast, lunch, supper, and at bedtime.</p> <p>R2's bladder urinary continence record from 7/20/23, through 7/25/23, identified:</p> <ul style="list-style-type: none"> -7/20/23 incontinent 2:27 a.m., 10:00 a.m., and 3:03 p.m. -7/21/23 incontinent 12:11 a.m. and 5:46 p.m. -7/22/23 incontinent 1:39 p.m., 1:59 p.m., and 2:46 p.m. -7/23/23 continent 5:31 a.m. and incontinent 10:22 a.m. and 2:37 p.m. -7/24/23 incontinent 12:04 a.m., 9:30 a.m., and 9:59 p.m. -7/25/23 incontinent 1:43 a.m., 9:28 a.m., and 5:42 p.m. <p>During an interview on 7/25/23 at 3:15 p.m. R2 stated staff came into their room, turned off call light and told me they would be right back, and no one came back. R2 indicated she then turned the call light on again 30 minutes later and staff repeated the same process. R2 verified it would take up to three hours to put her back to bed or get her up at times. R2 stated she knew staff were busy but counted on their word when they told her they would be right back and after a while they need to come back and take care of those they forgot. R2 also stated she felt like she had been forgotten and indicated she had complained</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 45</p> <p>to nurses, NA's and the social worker. R2 stated she hesitated to put on the call light when staff were so busy, staff made her feel like she made it harder on them when she used the call light, and she became frustrated. R2 stated felt tension in the air when staff started quitting and the remaining staff had told her they were required to pick up the slack. R2 identified they could do better but hard to do when short staffed frequently. R2 indicted the long wait times seemed to be worse in the afternoons between supper and 10:00 p.m., staff ran ragged and complained about how they were over worked. R2 stated once she was back in bed it became even harder to get staff to answer the call light to get help.</p> <p>During an observation on 7/26/23 at 8:30 a.m. R2 laid in bed and breakfast tray located on a bedside table, remained untouched and unreachable. At 8:56 a.m. dietary staff entered R2's room and attempted to removed breakfast tray from bedside table. R2 stated "No do not take that I have not eaten yet, the table was too far away". Dietary exited the room and R2's breakfast tray remained unreachable. At 8:57 a.m. R2 waved an unidentified staff over to her and requested the table be pulled closer to her so she could eat her breakfast. Staff assisted R2.</p> <p>R4's quarterly MDS dated 6/27/23, identified intact cognition and no behaviors. R4 required extensive assistance for bed mobility, transfers, personal hygiene, toileting, and dressing and total dependence for locomotion. R4 was always incontinent of bowel and bladder, high risk for pressure ulcers, and turning/repositioning program.</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 46</p> <p>R4's care plan dated 7/28/23, identified R4 had alterations in elimination related to a history of cerebral infarction (stroke), hemiplegia (weakness on one side of the body), spinal stenosis (narrowing), and incontinent of bladder at times. R4's care plan directed staff to provide incontinence care due to bowel and bladder incontinence to have kept R4 clean, dry, and odor free daily through staff assistance and interventions. R4 received diuretics (increased production of urine) seven out of seven days.</p> <p>R4's Kardex dated 7/28/23, identified R4 required assistance with turning every two hours and as needed, check and change and bedpan offered due to bowel and bladder incontinence. R4 required assist of two staff and a total lift to transfer.</p> <p>R4's bladder assessment dated 6/25/23, identified conditions impacted urinary continence included cerebral vascular accident, obesity, pain, and diabetes. R4 had functional incontinence (related to inability to toilet due to cognitive or physical functioning). R4's perception of the need to void was absent and required physical assistance in toileting.</p> <p>R4's bladder urinary continence record from 7/20/23, through 7/25/23, identified:</p> <p>-7/20/23, incontinent 9:52 p.m. and 5:15 p.m.</p> <p>-7/21/23, incontinent 12:06 a.m., 12:31 p.m., and 8:55 p.m.</p> <p>-7/22/23, incontinent 12:56 a.m., 1:59 p.m., and 2:38 p.m.</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 47</p> <p>-7/23/23, incontinent 5:25 a.m., 12:57 p.m., and 2:50 p.m.</p> <p>-7/24/23, incontinent 12:02 a.m., 9:32 a.m., and 9:52 p.m.</p> <p>-7/25/23, incontinent 1:38 a.m., 9:30 a.m., and 5:10 p.m.</p> <p>R4's bowel assessment dated 6/25/23, identified always incontinent of bowel.</p> <p>During an interview on 7/25/23 at 10:35 a.m. R4 laid in bed and alleged she had been laying in urine and stool for at least four hours now (See R4's bladder urinary continence record). R4 verified staff had not been checked and changed her since around 2:00 a.m. and that happened almost every day. R4 indicated she required assistance with cares and was unable to walk. R4 stated she would like to have received morning cares earlier today but found it difficult to get assistance from staff. R4 stated the lack of staff assistance had been going on for about four months now. R4 indicated the bed sheets were generally changed every day due to wet sheets from urine, she laid there too long. R4 stated on Saturdays she hollered for staff and reminded them she needed her shower otherwise was forgotten. R4 indicated she had placed her call light on, waited up to one hour, staff came in, shut off call light, and told R4 they would be back, and did not return. R4 stated it "broke her heart" she could not get the help she needed. R4 stated she wanted to be up out of bed and in her chair daily, and staff informed her they did not have time to get her up, so she stayed in bed.</p> <p>During an observation on 7/25/23 at 10:55 a.m.</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 48</p> <p>R4 placed her call light on and NA-C answered in at 11:09 a.m. (14 minutes). R4 asked to be changed and NA-C stated we needed to change your sheets also, required another staff to assist, and exited the room at 11:10 a.m.</p> <p>During an observation and interview on 7/25/23 at 11:45 a.m., (35 minutes later) NA-C and NA-D entered R4's room and applied gloves. NA-D and NA-C completed cares for R4. NA-D confirmed the brief had stool smeared on it and 50 percent saturated with urine. ND-C removed the sheets from R4's bed and placed them in a clear bag.</p> <p>R5's Significant change MDS dated 7/10/23, identified intact cognition and no behaviors. R5 required extensive assistance with personal hygiene, limited assistance with toileting, and supervision with transfers. R5 always continent of bowel and bladder. R5's diagnoses included anxiety disorder, depression, and schizophrenia. R5 received a diuretic seven out of seven days during look back period.</p> <p>R5's care plan dated 7/28/23, identified R5 had a ADL self-care deficit due to rheumatoid arthritis, diabetes mellitus, physical deconditioning, paranoid schizophrenia, morbid obesity, and poor eye sight. Staff were directed to assist R5 with bathing, dressing, toilet use, bed mobility, transfers assist of one in the morning and two assist after 8:00 p.m., and approach R5 warmly, positively, empathy, and understanding to bolster self-coping skills.</p> <p>R5's Kardex dated 7/28/23, identified R5 required assist of one to use toilet and complete personal hygiene.</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 49</p> <p>R5's bowel continence floor sheet dated 7/28/23 identified:</p> <p>-7/16/23 at 1:59 p.m. incontinent of bowel</p> <p>-7/26/23 at 9:31 p.m. incontinent of bowel</p> <p>During an interview and observation on 7/26/23 at 9:17 a.m., R5 sat in wheelchair with only a shirt and brief on and no shoes or slippers. R5 stated she had placed her call light on and had been waiting for assistance to wipe up the floor where she spilled her breakfast juice on her lap and then onto the floor. R5 stated staff took up to one hour to respond to the call light. R4 verified it had been hard to get help with anything especially on the evening and night shift, which seemed like staff did not want to come and answer it. R5 stated she had not complained about this, as she did not want to get any staff in trouble, but it made her mad and frustrated. R5 indicated she had a hard time getting fresh water, had waited up to 3 hours, and could pretty much do everything else for herself. At 9:37 a.m. (20 minutes later) NA-A knocked on door, entered the room and asked what she needed. R5 stated her wet pants needed to be picked up and NA-A stated, "oh is that all you needed?" NA-A cleaned up the floor with a towel and exited the room. R5 stated she tried to do as much for herself as possible but was unable to complete her own pericare and it was hard to get a staff to help. R5 added, staff have told her evening cares would be completed at 9:00 p.m. but staff do not come in until 10:00 p.m. Lastly, R5 added, her anxiety level increase when call light response times take so long and this affects her mental health.</p> <p>R6's significant change MDS date 5/15/23,</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 50</p> <p>identified intact cognition and no behaviors. R6 required extensive assistance with bed mobility, dressing, personal hygiene, toileting, and total dependence on staff for transfers. R6 frequently incontinent of bladder and occasionally incontinent of bowel. R6's diagnoses included anxiety and manic depression.</p> <p>R6's care plan dated 7/28/23, identified R6 had limited physical mobility related to muscle weakness, deformities of the foot, essential tremors, morbid obesity, chronic pain, fibromyalgia, and contractures of the left hand. R6's care plan directed staff to transfer R6 full body lift and assistance of two staff and routinely turn and reposition at least every two hours.</p> <p>R6's Kardex dated 7/28/23, identified, R6 needed encouragement to off load and/or change positions at least every 2 hours and incontinent of bladder at times.</p> <p>During observation on 7/25/23 at 12:40 p.m. R6's call light was noted to be on. Activities staff walked down hallway past R6's room, entered a neighbor's room, and did not answer the call light.</p> <p>During an interview on 7/25/23 at 12:45 p.m. R6 stated she placed call light on a bit ago, NA-A turned call light off, informed R6 would look for another staff to help her. R6 stated she had waited up to approximately 45 minutes at times to receive assistance from staff. R6 stated she had just placed call light on again and waited for assistance. R6 confirmed she had urine accidents, it had been a while, she tried to hold it until staff came to help her. R6 stated staff got upset when she would ask for small things usually during the evening and nighttime shifts.</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 51</p> <p>R6 stated she had been told by staff they have other people to take care of and to get to the point, and were in a rush to leave her room. R6 stated she understood they were busy but it only took a few minutes to help her and made her feel like she was a burden to them.</p> <p>During an observation on 7/25/23 at 12:55 p.m. NA-A and NA-D entered R6's room, turned call light off and assisted R6 with toileting.</p> <p>R6's call light log on 7/25/23, identified:</p> <ul style="list-style-type: none"> -call light was activated at 12:27 p.m. and was responded to 2 minutes 56 seconds after it was activated. -call light was activated at 12:38 p.m. and was responded to 14 minutes 41 seconds after it was activated. -call light was activated at 12:59 p.m. and was responded to 10 minutes 23 seconds after it was activated. <p>R6 received assistance with toileting almost 30 minutes after she had placed the call light on initially.</p> <p>R7's Admission MDS dated 7/12/23, identified intact cognition and no behaviors. R7 required extensive assistance with bed mobility, dressing, toilet use, personal hygiene and total dependence with transfers. R7 was frequently incontinent of bowel and bladder with a history of urinary tract infections.</p> <p>R7's care plan dated 7/18/23, identified R7 had an ADL self-care deficit related to osteoporosis</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 52</p> <p>pain, muscle spasms, weakness, and deconditioning. Staff were instructed to provide assist of two with sit to stand lift, keep pressure off of left lower heel/extremity, and may use bedside commode for toileting.</p> <p>Interview on 7/26/23 at 1:20 p.m., R7 laid in bed on her back. R7 stated the call light wait times get to be long in the morning because they are short staffed. R7 stated two weeks ago, she placed her call light on early in the morning around just after 9:00 a.m. and took staff over 20 minutes later staff came in, turned off call light, informed her they would be right back, and staff returned much later. R7 stated she laid in bed from 7:00 a.m. to 10:30 a.m. incontinent of urine, and wanted to be up by at least 9:00 a.m. R7 stated she has to wait up to two hours to get laid down and staff tell me they will help, but do not come back. R7 stated she felt so helpless and unable to get help when needed.</p> <p>On 7/12/23, R7's call light was activated at 9:12 a.m. and was responded to 25 minutes 33 seconds after it was activated.</p> <p>Review of R7's urinary continence dated 7/12/23 at 10:37 a.m. R7 was incontinent of urine.</p> <p>R8's Significant change MDS dated 6/27/23, identified intact cognition and no behaviors. R8 required extensive assistance with bed mobility, dressing, and toilet use and limited assistance with personal hygiene, and transfers. R8 was occasionally incontinent of bladder and always continent of bowel. R7 received a diuretic 7 out of 7 days during the look back period.</p> <p>R8's care plan dated 7/28/23, identified an ADL</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 53</p> <p>self-care deficit related to chronic right shoulder pain and obesity. Staff were instructed to provide assistance with peri cares to help avoid further urinary tract infections and check and change as needed due to incontinence.</p> <p>R8's Kardex identified required assistance of one for bathing and assistance with lower body cleansing.</p> <p>During an interview on 7/26/23 at 12:51 p.m. R8 stated they are short staffed quite often, especially on weekends. R8 stated this past Saturday on 7/22/23, staff called in sick and there was (verified by schedule)only one staff on the floor for about two hours. R8 indicated she did had not received her scheduled shower that day. R8 stated last evening on 7/25/23, NA-A arrived in her room and instructed her to turn the call light off. R8 stated she asked NA-A for a gown and assistance with evening cares, NA-A left the room and did not return. R8 stated she placed call light on again that evening but no one came so R8 turned off light, and fell asleep in her clothing. R8 stated she does not feel the facility has enough staff to meet our needs. R8 stated earlier this month, used call light early in the morning, and waited up to over and hour for assistance. R8 also stated on 7/26/23, she had been yelled at by an NA at 6:30 a.m. when she placed her call light on before 6:30 a.m. and was told to not to use the call light prior to 6:30 a.m., staff were in report. R8 stated she waited until closer to 8:00 a.m. placed the call light on again and received assistance. R8 stated had not told any one because it would not do any good. R8 stated she would have told the social worker but had previously talked to her, and had not received much help. R8 indicated she does usually</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 54</p> <p>attended the resident counsel meeting, but was in too much pain to attend the last one. R8 had brought up concerns during a previous resident counsel meeting and nothing was really resolved.</p> <p>Review of facility staff schedule day shift on 7/22/23 identified: day shift 6:00 a.m. to 2:30 p.m. one float NA and 7:00 a.m. to 2:30 p.m. one NA, and one nurse. (short NA from 6:00 a.m. to 7:00 a.m. and 9:30 a.m. to 10:30 a.m. and short two NA's from 10:30 a.m. to 2:30 p.m.) one nurse 6:00 a.m. to 7:15 a.m. two nurses from 7:15 a.m. to 8:30 a.m., three nurses 8:30 a.m. to 10:30 a.m., two nurses 10:30 a.m. to 2:30 p.m. (short nurse from 6:00 a.m. to 7:15 a.m.)</p> <p>Review of the call light times for R8 revealed on 7/26/23, her call light was activated at 6:27 a.m. and not again until 7:50 a.m.:</p> <p>On 7/26/23, the call light was activated at 6:27 a.m. and was responded to 13 minutes 3 seconds after it was activated.</p> <p>On 7/26/23, the call light was activated AT 7:50 a.m. and was responded to 41 seconds after it was activated.</p> <p>R8's shower/bathing record indicated no shower/bath was documented as completed on 7/22/23, as indicated by R8 in interview.</p> <p>During an interview on 7/26/23 at 2:07 p.m. NA-A stated did not assist R8 with evening cares last night, no recall of answering R8's call light, and R8 did not need help with cares anyway.</p> <p>R11's Significant change MDS dated 7/26/23,</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 55</p> <p>identified intact cognition and no behaviors. R11 required extensive assistance for bed mobility, transfers, personal hygiene, toileting, dressing, and locomotion. R11 was occasionally incontinent of bladder and frequently incontinent of bowel with a history of bladder infections.</p> <p>R11's care plan dated 7/28/23, identified R4 had an activities of daily living (ADL) self-care deficit related to contractures of bilateral hands, altered mental status, low back pain, and weakness. R11 required assist of two staff for toilet us. Staff were directed to offer toileting every two hours.</p> <p>R11's Kardex dated 7/28/23, identified R4 required assist of two and EZ stand to transfer and offer toileting every two hours and document refusals.</p> <p>R11's Bladder evaluation dated 7/26/23, identified frequently incontinent due to memory problems, impaired decision making, required physical assistance in toileting, obesity, and diabetes. R4's perception of need to void was diminished.</p> <p>During an interview on 7/26/23 at 1:39 p.m. R11 stated she placed call light on this morning around 8:45 a.m. and it took over 30 minutes for the staff to respond to it. R11 also stated call light did not seem to work at times with how long she had waited for staff to answer it. R11 stated she required assistance of staff and a stand lift to get up to the commode but had urine and stool accidents consistently because of the long wait times to get help. R11 stated when she had accidents, she did not feel very good about herself and felt embarrassed by it. R11 also stated she placed her call light on at about 1:15 p.m. and it was now 1:45 p.m. and no staff had</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 56</p> <p>answered it yet. R11 indicated she tried to hold her urine as long as she could but currently had urinary tract infection and it had become difficult to do so. R11 requested surveyor please let staff know she needed help to the bathroom because she was not sure how much longer she could hold it before she had an accident in her pants.</p> <p>Observation on 7/26/23 at 1:52 p.m. two call lights R6 and R11 had been on since 1:45 p.m. located in the same hallway. NA-A walked down hallway to the room next to R11's room carried clean linen, walked into the neighbor's room, and closed the door. Seven minutes later at 1:55 p.m. NA-A walked out of room, did not answer R6 or R11's call lights, and walked down the hallway to the nurse's station slowly.</p> <p>Observation on 7/26/23 at 1:55 p.m. NA-B walked into R11's room, shut off call light, said she would someone to help her and be back, and exited room. NA-B then walked into R6's room, shut off call light, said the same thing and exited the room. NA-B walked back down the hallway to the nurse's station.</p> <p>Observation on 7/26/23 at 2:01 p.m. NA-G walked down hallway and into R11's room and asked, "you need to go to the bathroom?" R11 stated, "yes, really bad." NA-G exited the room, walked down the hallway and returned to R11's room at 2:03 p.m. NA-G placed gloves on his hands and informed R11 he had to wait for assistance of another staff. At 2:10 p.m. NA-A entered R11's room, placed gloves on her hands, raised resident up off wheelchair with the sit to stand lift and lowered her onto the commode. NA-G verified R11's brief was dry, gave R11 a call light, exited the room. NA-A and NA-G did not</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 57</p> <p>enter R6's room across the hallway and walked the towards the nurse's station.</p> <p>During an interview on 7/25/23 at 3:15 p.m. LPN-A stated staffing was ok on the day and night shifts but evening shift struggled to get all cares and charting completed by the end of their shift. LPN-A confirmed agency staff was filling in tonight due to being short three staff.</p> <p>During an interview on 7/26/23 at 2:34 p.m., NA-E stated they needed more staff to complete all tasks. NA-E stated they had answered one residents call light 15 times already this shift. NA-E indicated there were times when a resident only needed something simple like a television channel changed or asked to be covered up. NA-E confirmed approximately one half of the residents were incontinent of urine by the time they got to them today. NA-E confirmed floor nurses did not answer call lights but trained medication aids (TMA) answered call lights occasionally.</p> <p>During a follow up interview on 7/27/23 at 9:51 a.m., NA-E indicated it was hard to keep up with meeting the resident's basic needs such as toileting and bathes when not enough staff were scheduled. NA-E verified only two staff worked today along with one person training. NA-E also indicated occasionally a NA floated between the two floors and helped out.</p> <p>During an interview on 7/28/23 at 12:16 p.m. staffing coordinator (SC) stated the facility was staffed according to the census and ratios identified using a computer program. SC indicated the nursing staff schedule was completed one month ahead of time with an</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 58</p> <p>average of 10 to 15 NA shifts open a week and 10 nursing shifts were open a week. SC stated she sent out message to all staff and talked to staff individually to fill open shifts. SC stated yesterday on 7/27/23 the facility was short three staff and she had filled them by 8:00 a.m. SC also stated NA's came to her approximately twice a month and informed her there was too much work and too hard of work even when fully staffed. SC stated every other weekend the facility worked short staffed, usually short one NA. SC stated she was unaware as to what the staff cannot get done on their shifts.</p> <p>During an interview on 7/28/23 at 12:56 p.m., assistant director of nursing (ADON) stated they were not aware of any concerns staff regarding staffing and expected the staffing scheduler to have filled the schedule. ADON also stated call lights averaged much less than 10 minutes and audits would have been completed by the social worker. ADON expected staff to prioritize how quickly they answered the call lights and go to the residents first with safety issues. ADON expected staff to take care of the residents and was unable to place a length of time on the expectation regarding answering call lights.</p> <p>During an interview on 7/28/23 at 1:26 p.m. social worker (SW) stated staff and residents had complained about long call light times. SW indicated the entire second floor was looked at for one week regarding long call wait times and majority of the call lights were under 15 minutes, some longer, and one was 30 minutes. SW stated these results were shared with DON and ADON and talked about the findings, no notes were taken during this audit or meeting. SW stated they had planned a weekly call light audit</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 59</p> <p>for the next three weeks, so the long call light wait times and any trends or specific rooms could be addressed accordingly. SW stated up to a 30 minute wait time would be the maximum time a resident should have to wait for the call light to be answered.</p> <p>During an interview on 7/28/23 at 1:44 p.m. LPN-B stated there were not sufficient staff to meet the needs of resident and provide safe care especially when residents were first admitted. LPN-B stated facility had a high turnover rate of residents with a high acuity. LPN-B stated frequently only two NA's would be scheduled to care for over 30 residents and needs such as toileting and basic cares were not being met.</p> <p>During an interview on 7/28/23 at 1:52 p.m., NA-F stated staffing was an issue, adding two NA's were not enough to care for 33 residents. NA-F indicated they felt rushed through all cares and was unable to take the time needed to care for residents properly. NA-F stated our equipment such as lifts do not work properly, batteries are worn out, and residents are up in the air longer than they should be. NA-F verified approximately 75% of the residents were already incontinent prior to getting assistance from staff due to the length of time it took to get to each one and that should not be happening. NA-F stated most of the time when the facility is short staffed it is due to call ins. NA-F indicated they work three double shifts a week due to shortage of staff. NA-F also stated resident wait times are longer than they should be due to staff turning off the call light, informed resident they will return with help, then get busy, and forget to go back to assist them.</p> <p>During an interview on 7/28/23 at 4:30 p.m.,</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 60</p> <p>director of nursing (DON) stated facility had a staffing coordinator who handled the schedule in general. DON confirmed the assistant director of nursing and herself worked on the floor when needed as well as the health unit coordinator to ensure there was appropriate staffing levels. DON stated two nurse and two to three nursing assistants were more than adequate staff for the main floor and was in fact, better than "normal".</p> <p>FACILITY STAFFING SCHEDULE On 7/28/17, at 12:16 p.m. the facility SC confirmed she developed the facility's staffing pattern and the staffing pattern was based upon the facility census. SC indicated the current staffing pattern for second floor included the following guidelines:</p> <p>Second floor: -Day shift; three NA's and two nurses -Evening shift; two and one half to three NA's and two nurses -Night shift; one and one-half to two NA's and one nurse</p> <p>Also during interview, SC stated the acuity on the night shift has gone up because more residents care needs increased.</p> <p>The facility weekly second floor staffing schedule from 7/17/23 through 7/22/23 identified:</p> <p>7/17/23 day shift 6:00 a.m. to 2:30 p.m. two NA's, 6:00 a.m. to 8:45 a.m. one NA, and two licensed nurses, and one trained medical assistant (TMA). (short NA from 8:45 a.m. to 2:30 p.m.)</p> <p>7/18/23 day shift 6:00 a.m. to 2:30 p.m. one NA, 10:00 a.m. to 2:30 p.m. one NA, 6:00 a.m. to</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 61</p> <p>11:00 a.m. one NA training another new NA, and two nurses and a TMA. (short NA from 11:00 a.m. to 2:30 p.m.)</p> <p>7/18/23 evening shift 2:00 p.m. to 10:30 p.m. one nurse, 2:00 p.m. to 4:00 p.m. one nurse, and 4:00 p.m. to 10:30 p.m. one nurse. (short one nurse)</p> <p>7/19/23 day shift 6:00 a.m. to 2:30 p.m. one NA, 8:00 a.m. to 2:30 p.m. one NA and one in training and two nurses. (short two NA's from 6:00 a.m. to 8:00 a.m. and short one NA from 6:00 a.m. to 2:30 p.m.)</p> <p>7/19/23 evening shift 2:00 p.m. to 10:30 p.m. two NA's and 5:00 p.m. to 8:00 p.m. one NA, and 2:00 p.m. to 10:30 p.m. one nurse, and 2:00 p.m. to 10:30 p.m. one nurse. (short NA from 2:00 p.m. to 5:00 p.m. and 8:00 p.m. to 10:30 p.m.)</p> <p>7/19/23 night shift 10:00 p.m. to 6:30 a.m. one NA and one nurse. (short one NA from 10:00 p.m. to 6:30 a.m.)</p> <p>7/20/23 day shift 6:00 a.m. to 2:30 p.m. three NA's and 6:00 a.m. to 2:30 p.m. two nurses.</p> <p>7/20/23 evening shift 2:00 p.m. to 6:00 p.m. 3 NA's, 6:00 p.m. to 9:00 p.m. 3 NA's and one in training. 9:00 p.m. to 10:30 p.m. one NA and one in training (short one NA from 9:00 p.m. to 10:30 p.m.), one nurse from 2:00 p.m. to 10:30 p.m. and one nurse from 2:00 p.m. to 8:30 p.m. (short one nurse from 8:30 p.m. to 10:30 p.m.)</p> <p>7/20/23 night shift 10:00 p.m. to 2:30 a.m. two NA's with one in training and 2:30 a.m. to 6:30 a.m. one NA with one in training (short NA from 2:30 a.m. to 6:30 a.m.)</p>	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	<p>Continued From page 62</p> <p>7/21/23 day shift 6:00 a.m. to 2:30 p.m. two NA and two nurses with one training (short NA 6:00 a.m. to 10:30 p.m.)</p> <p>7/21/23 evening shift 2:00 p.m. to 9:00 p.m. three NA's, 9:00 p.m. to 10:30 PM two NA's (short NA from 9:00 p.m. to 10:30 p.m.) and 2:00 p.m. to 10:30 PM one nurse, 2:00 p.m. to 8:30 p.m. (short nurse from 8:30 p.m. to 10:30 p.m.)</p> <p>7/22/23 day shift 6:00 a.m. to 2:30 p.m. one float NA and 7:00 a.m. to 2:30 p.m. one NA, and one nurse. (short NA from 6:00 a.m. to 7:00 a.m. and 9:30 a.m. to 10:30 a.m. and short two NA's from 10:30 a.m. to 2:30 p.m.) one nurse 6:00 a.m. to 7:15 a.m. two nurses from 7:15 a.m. to 8:30 a.m., three nurses 8:30 a.m. to 10:30 a.m., two nurses 10:30 a.m. to 2:30 p.m. (short nurse from 6:00 a.m. to 7:15 a.m.)</p> <p>7/22/23 evening shift three NA's from 2:00 p.m. to 4:30 p.m., 2:00 p.m. to 6:00 p.m. three NA's, 6:00 p.m. to 7:30 p.m., two NA's 7:30 p.m. to 9:00 p.m., one NA 9:00 p.m. to 10:30 p.m. (short NA 7:30 p.m. to 9:00 p.m. and short two NA's from 9:00 p.m. to 10:30 p.m.)</p> <p>Facility daily census dated 7/28/23, identified:</p> <ul style="list-style-type: none"> -current census on second floor 33 residents -9 residents independent -12 residents required assistance of one staff to transfer -12 residents required assistant of two staff to transfer 	F 725		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 725	Continued From page 63 Facility policy titled Sufficient Staffing dated 6/30/20 identified sufficient staffing would be provided to assure adequate staff are available to provide quality nursing care. Nursing direct care staffing ratios will be figured daily with changes in census and level of care needs made based on number of residents and the level of care necessary with administrator approval. Random scheduled resident interviews are conducted to assess satisfaction with care needs being met and considered when staffing ratios were determined.	F 725			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		8/28/23	

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 64</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p>	F 880		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 65</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to ensure proper infection prevention on shared resident equipment and hand hygiene practices to prevent the spread of infection for 1 of 3 (R4) residents observed during care.</p> <p>Findings include:</p> <p>R4's quarterly Minimum Data Set (MDS) dated 6/27/23, R4 required extensive assistance for bed mobility, transfers, personal hygiene, toileting, and dressing and total dependence for locomotion. R4 was always incontinent of bowel and bladder, high risk for pressure ulcers, and turning/repositioning program.</p> <p>R4's Kardex dated 7/28/23, identified R4 required assistance with turning every two hours and as needed, check and change and bedpan offered. R4 required assist of two staff and a total lift to transfer.</p> <p>During an observation on 7/25/23 at 11:45 a.m. nursing assistant (NA)-C and NA-D entered R4's room and applied gloves. R4 laid in bed on her back. NA-D removed front of R4's brief and sprayed cleanser foam in peri area. NA-D wiped R4's peri area from front to back with two separate wipes. NA-D rolled R4 onto her right side, NA-C cleaned R4's rectal area from front to back, and confirmed there was stool and 50 percent saturated with urine in brief. NA-D removed gloves, did not sanitize her hands,</p>	F 880	<p>F880</p> <p>The facility failed to ensure proper infection prevention on shared resident equipment and hand hygiene practices to prevent the spread of infection for 1 of 3 (R4) residents observed during care.</p> <ol style="list-style-type: none"> R4 has been monitored and no signs and symptoms of infection have been noted. Every resident in the facility has the potential of being affected by this deficient practice. Sani-wipes placed in all the bags of the lifts and stock of Sani-wipes ordered. Individual hand sanitizers purchased. Nursing staff educated to keep hand sanitizer on his/her person as best practice. Education provided related to handwashing and sanitizing equipment between residents. Audits developed to be completed and audited by the DON, or designee, 3x weekly for 4 weeks, then weekly for 2 months and will be presented at QAPI for review. This deficiency will be corrected 8/28/23 	

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 66</p> <p>placed and pulled up R4's brief. NA-D used bare hand to push up her glasses, and wiped her face with the inside of her shirt neck. NA-D then wiped her own forehead, removed sweat with her left hand two times, and grabbed the inside of her own shirt to wipe her lips with the outside of the shirt. NA-D applied and pulled up R4's shorts to her thighs, grabbed R4's left hand to help her lean forward, pulled the back side of her shirt down, and placed R4' missing sock back onto her foot. NA-D placed R4's lift sheet underneath her and pulled up between her legs. NA-D washed hands in bathroom with soap and water and NA-C removed gloves and sanitized hands prior to exiting the room.</p> <p>During an observation on 7/26/23 at 8:59 a.m. R4 laid in bed with door closed, lower body exposed. NA-B pulled privacy curtain. NA-A with gloved hands placed powder in R4's peri area, abdominal fold, and under her left breast. Together NA-A and NA-B rolled R4 side to side, placed brief, tank top, and pants. NA-A covered R4 with a blanket and NA-B removed gloves, did not sanitize her hands, and placed the call light next to R4. NA-A picked up a pile of dirty linen off the floor, placed it in a clear bag and left linen bag on floor open. NA-A pushed the total lift machine out of the room with the same gloves on, did not disinfect the mechanical lift and then re-entered R4's room. NA-A picked up R4's breakfast tray with the same gloves on, walked out into the hallway, placed breakfast tray on a cart, and immediately returned to R4's room. NA-A continued to wear the same gloves placed R4's personal linen in a separate bag, grabbed the garbage bag that contained a wet brief in it, tied it shut, and placed both bags and an empty pop box on top of the shower chair. NA-A did not</p>	F 880		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 67</p> <p>remove gloves then assisted R4's roommate. NA-A picked up R4's roommate with her oxygen tubing and placed it on her face with her gloved hands and did not remove gloves or sanitize her hands. NA-A pushed the shower chair out of the room, down the hallway, and into the shower room. NA-A placed bags of dirty linen, clothing, and garbage in appropriate bins, removed gloves then washed hands with soap and water.</p> <p>During an interview on 7/25/23 at 1:40 p.m. NA-D verified she had applied gloves, completed peri cares, removed gloves, and did not sanitize hands. NA-D indicated with bare hands removed R4's shirt, applied clean shirt, held R4's left hand and assisted with a lean forward, pulled down the back of the shirt, placed brief and missing sock, pulled up R4's shorts, and placed lift sheet underneath R4. NA-D stated hand hygiene should have been completed right after the removal of the dirty gloves and prior to completing other cares especially when R4's hand was held, to prevent the transfer of germs. NA-D also confirmed R4's hands were not sanitized after cares and prior to when she was taken to the dining room for lunch and should have been.</p> <p>During an interview on 7/25/23 at 2:30 p.m. NA-B stated staff are expected to use good hand hygiene going in and out of resident's rooms, after touching anything dirty, after taking off gloves and prior to touching other things. NA-B verified good hand hygiene was necessary to make sure they are clean and helped avoid spread of germs.</p> <p>During an interview on 7/25/23 at 3:15 p.m. licensed practical nurse (LPN)-A stated staff were expected to complete hand hygiene prior to</p>	F 880		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 68</p> <p>entering and exiting a resident's room, after the removal of gloves especially after peri cares, and prior to assistance with other cares. LPN-A indicated good hand hygiene helped prevent bacteria on the hands and transfer of germs from one place to another.</p> <p>During an interview on 7/26/23 at NA-A confirmed the events in R4's room and that she assisted R4's roommate with her oxygen with the same gloves on. NA-A confirmed she did not wipe down the mechanical lift machine or the shower chair after it was used by R4. NA-A stated staff are expected to sanitize/wipe down and disinfect the total lift with a bleach wipe and shower chair with a disinfectant spray after each resident use to help prevent the spread of germs and immediately remove gloves and perform hand hygiene after peri care before starting other care tasks.</p> <p>During an interview on 7/27/23 at 10:03 a.m. housekeeping (H)-B verified she had worked at facility for 38 years and nursing staff were expected to disinfect the shower chairs in between every resident to help prevent the spread of infection from one resident to another. H-B stated housekeeping were expected to clean the shower room once a day after all showered were completed for that day.</p> <p>During an interview on 7/28/23 at 12:56 p.m. assistant director of nursing (ADON) stated staff were expected to complete hand hygiene prior entering and exiting any resident room, prior to application of gloves, after removal of gloves especially after peri cares to prevent the spread of infection.</p>	F 880		

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

PRINTED: 08/30/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023
NAME OF PROVIDER OR SUPPLIER FAIR OAKS NURSING & REHAB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 69 Review off facility policy titled Hand Hygiene dated 1/16/23, identified proper and appropriate hand washing and hygiene techniques would aid in the prevention of transmission of infections. Staff were expected to perform hand hygiene by washing hands for at least twenty seconds with antimicrobial or non-antimicrobial soap with water before application and removal of gloves, before moving from contaminated body site to a clean body site during resident care such as providing peri cares. Review of facility policy titled Cleaning and Disinfection of Resident Care Equipment dated 3/8/23, identified reusable equipment such as shower chairs and mechanical lifts were expected to be cleaned and disinfected after use of one resident and before the use of another resident.	F 880			