DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 21, 2025

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

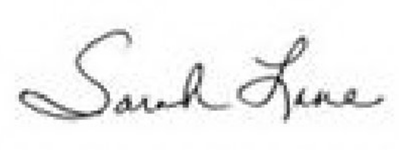
RE: CCN: 245581
Cycle Start Date: January 14, 2025

Dear Administrator:

On February 5, 2025, 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,



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

February 21, 2025

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

Re: Reinspection Results
Event ID: DY2V12

Dear Administrator:

On February 5, 2025 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 January 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
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Minnesota Department of Health
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 17, 2025

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

RE: CCN: 245581
Cycle Start Date: January 14, 2025

Dear Administrator:

On January 14, 2025, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction

occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 14, 2025 (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 July 14, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

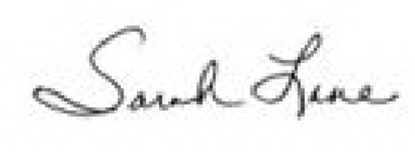
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 17, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: DY2V11

Dear Administrator:

The above facility was surveyed on January 13, 2025 through January 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please feel free to call me with any questions.

Sincerely,

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
February 21, 2025

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

RE: CCN: 245581
Cycle Start Date: February 12, 2025

Dear Administrator:

On February 12, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
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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 May 12, 2025 (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 August 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

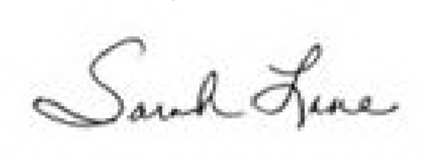
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	C 01/14/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/13/25 to 1/14/25, 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 complaint was reviewed. H55814620C (MN00109703) AND The following complaints were reviewed. -H55814583C (MN00109699), with deficiencies issued at F550, F919 -H55814640C (MN00109265), with a deficiency issued at F550 -H55814641C (MN00104528), with deficiencies issued at F609, F610 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=D	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	F 550		1/29/25

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

Electronically Signed | 01/23/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	C 01/14/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 access to persons and services inside and outside the facility, including those specified in this section. §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. §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. §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. §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. §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 document	F 550	1. R1 was discharged from facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	C 01/14/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 review, the facility failed to ensure dignity was maintained for 1 of 3 residents (R1) who had unwanted facial hair present, reviewed for dignity. Findings Include: R1's admission Minimum Data Set (MDS) dated 12/17/24, identified R1 was cognitively intact, and had diagnoses which included: hypertension, diabetes mellitus, respiratory failure, and fracture in past six months. Indicated R1 was dependent on staff for transfers, dressing and personal hygiene, which included shaving. R1's Care Area Assessment (CAA) dated 12/20/24, identified R1 had an activities of daily living (ADL) self-care performance deficit related to (r/t) collapsed vertebra, and was working with therapy. Indicated R1's care plan for self-care deficit and impaired physical mobility would be completed. Staff would assist with ADL completion and encourage self-participation. R1's care plan revised 12/30/24, identified R1 had an ADL self-care performance deficit related to collapsed vertebra. R1's interventions included personal hygiene assist of one staff. Review of R1's progress notes from 12/10/24 to 1/13/25, lacked documentation R1 refused to have facial hair removed. During an observation and interview on 1/13/25 at 10:46 a.m., R1 was in his room in a recliner, dressed in street clothes, and family member (FM)-A was present. R1 had a large amount of white facial hair on chin approximately one fourth inch long. R1 indicated it bothered her and staff were to assist her with removing the facial hair.	F 550	2. All residents have the potential to be affected by this deficient practice. All residents audited for facial hair 1/14/2025; facial hair removed per preference as applicable. Care plans will be updated accordingly to ensure their preferences are respected and incorporated. 3. All nursing staff will be educated on facility policies: Activities of Daily Living and Resident Rights: Dignity. All nursing staff will be educated to ensure residents' facial hair is removed per preferences. Care plans will be updated with preferences for managing facial hair for all new admissions and changes to resident preference. 4. Audits will be completed twice weekly x 1-month, weekly x 1 month, every other week x 1 month, and monthly x 1 month to ensure dignity is maintained by removing unwanted facial hair for all residents. Results and analysis of these audits will be brought to QAPI committee to review and determine frequency of ongoing audits. Director of Nursing and or designee is reponsible for monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	C 01/14/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 R1 stated staff had not offered to remove her facial hair and she wanted it removed. During an interview on 1/13/25 at 11:06 a.m., nursing assistant (NA)-A, indicated she had not taken care of R1 for a few days, however would have removed R1's facial hair if it was present and visible. At 11:23 a.m. NA-A entered R1's room then after leaving R1's room, confirmed R1 had a large amount of facial hair present and indicated R1 should have been shaven. During an observation on 1/13/25 at 11:38 a.m., R1 was in recliner in her room, and facial hair had been removed. R1 rubbed her chin and indicated NA-A had removed her facial hair, which was really nice and she felt better. During an interview on 1/13/25 at 2:42 p.m., licensed practical nurse (LPN)-A stated she was aware R1 needed to have facial hair removed. LPN-A indicated FM-A was going to bring in a new razor for R1, and was unaware if the facility had razors they could use if residents did not have their own. LPN-A stated she expected staff to assist with removing facial hair when observed, had also assisted residents with removing facial hair, and had shaven R1 herself in the past. LPN-A was not aware R1 had ever refused to have facial hair removed. During an interview on 1/13/25 at 3:24 p.m,, director of nursing (DON) confirmed R1 was cognitive and was able to express her needs. DON indicated her expectation was that staff would assist residents to remove unwanted facial hair as it was important for maintaining a resident's dignity.	F 550		

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F 550	Continued From page 4 The facility policy titled Activities Of Daily Living (ADLs) dated 3/15/21, identified based on comprehensive assessment of a resident and consistent with the residents's needs and choices, the facility would provide the necessary care and services to ensure that a resident's abilities in activities of daily living did not diminish unless circumstances of the individual's clinical condition demonstrated that such diminution was unavoidable. The policy identified the facility would provide care and services for the following ADLs, which included: hygiene-bathing, dressing, grooming, and oral care. ADL cares would be provided based on the resident preferences. If the resident refused care, that would be reported to the nurse and the resident re-approached. Documention of refusal would be completed in the electronic medical record. The facility policy titled Resident Rights: Dignity revised 10/24/23, identified the facility would treat each resident with respect and dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility would protect and promote the rights of the residents. The policy further identified federal and state laws guaranteed certain basic rights to all residents of the facility and these rights included the resident's right to a dignified existence, and to be treated with respect, kindness, and dignity.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		1/29/25

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F 609	Continued From page 5 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure an allegation of employee to resident abuse was immediately reported no later than two hours, to the State agency (SA) for 1 of 3 residents (R4) reviewed for abuse. Findings include: R4's quarterly Minimum Data Set (MDS) dated 12/27/24, identified R4 had severe cognitive impairment and diagnoses which included:	F 609	1. R4 did not have any negative impact from incident. Allegation of abuse was reported to the state agency after notification through survey. This allegation was investigated at time of incident 6/2024 however was not reported to state agency at that time. 2. All residents have the potential to be affected by this deficient practice. Leadership team has been re-educated	

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F 609	Continued From page 6 Alzheimer's disease, anxiety and depression. R4's MDS indicated R4 had no behaviors and was dependent on staff for transfers, eating, dressing and personal hygiene. R4's Care Area Assessment (CAA) dated 9/30/24, identified R4 had severe cognitive impairment and was unable to follow a conversation and answer appropriately. R4 had signs of short term memory, and was unable to recall what a daily object was such as a shirt, television, bed or colors. R4 attempted to hit staff while they were doing cares. Staff were unable to redirect R4 when R4 had these behaviors. R4's care plan revised 1/2/25, identified R4 had an activities of daily living (ADL) self-care performance deficit and limited physical mobility with interventions which included: assistance for bathing/showering, dressing, personal hygiene toilet use, and transfers with two staff and a Hoyer (mechanical) lift. Indicated R4 had impaired cognitive function, and vulnerability of self and or others related to cognitive impairments/dementia, decreased cognition, medical condition/situation. Interventions included to provide safe environment and remove R4 from potentially abusive situations. During an interview on 1/14/25 at 9:39 a.m., NA-C indicated R4 was usually pretty quite, sang a lot and required total assistance with cares. NA-C stated at times R4 could be a little resistive to cares, and R4 was not fond of her oxygen and would push staff away. NA-C indicated she had reported an allegation of employee to resident abuse to human resources director (HR)-A back in June, 2024. NA-C indicated she had reported that trained medication aide (TMA)-A said R4	F 609	regarding timeline for reporting suspicions of abuse through the Abuse policy. 3. Administrator of record at the time of this allegation is no longer employed with the organization. Current Administrator and Director of Nursing educated on facility policy title Vulnerable Adult Abuse and Neglect Prevention to include ensuring all allegations and/or suspicions of abuse are reported to the state agency immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury 4. Audits have been developed regarding timeliness of VA reporting audits. Audits will be completed by DON and/or designee 2x/wk for 4 weeks, then weekly for 4 weeks to ensure all allegations and/or suspicions of abuse are reported to the state agency immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury. Results and analysis of these audits will be brought to QAPI committee to review and determine frequency of ongoing audits. Administrator and or designee is reponsible.	

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F 609	Continued From page 7 swatted at her, and she heard TMA-A tell R4 "don't you hit me, do you want me to hit you?". NA-C stated she felt that was emotionally abusive towards R4, so she reported it to HR-A. NA-C stated she was unaware if anything was done about it, as TMA-A worked the next day. During an interview on 1/14/25, at 9:56 a.m., HR-A stated the allegation of abuse NA-C had reported sounded vaguely familiar, however could not remember the details or circumstances. HR-A stated her usual process if allegations were reported to her, was to notify the staff member's supervisor, director of nursing (DON) or administrator. HR-A indicated it may have been documented in TMA-A's employee file. HR-A opened TMA-A's file and produced a copy of TMA-A's Employee Counseling Record dated 6/28/24. Review of TMA-A's Employee Counseling Record dated 6/28/24, included the following: -type of notice: coaching and verbal warning were identified by their boxes checked. -detail of description of the problem: It was alleged that staff member yelled at resident, "Do you want me to hit you?" -detailed description of corrective action: When addressing residents staff members must not be verbally abusive. Federal and state law guarantee that certain basic rights to all residents of this facility. You are expected to do Eden Essentials Part 1, due by the end of today, June 28, 2024. -Form signed by employee, DON and HR-A. During a telephone interview on 1/14/25 at 11:18 a.m., TMA-A indicated she remembered the incident in June, 2024. TMA-A stated residents would hit out when they least expected it, so	F 609		

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F 609	Continued From page 8 TMA-A attempted to teach residents if they had dementia just like they would teach children. TMA-A indicated she had received dementia training, and confirmed teaching residents with dementia like children was not part of the training, just something she had picked up over the years. TMA-A stated DON had spoken to her about the incident, and told her she should not say those things, as a family member could be close by and could hear her. TMA-A indicated she was not trying to be mean, just was trying to teach R4. TMA-A said she was written up for the incident. During an interview on 1/14/25 at 12:10 p.m., DON indicated the allegation of abuse made on 6/28/24, could have been considered abusive, however the prior administrator was made aware and they decided it was not an act of abuse. DON confirmed the allegation of abuse was not reported to the SA, and it was important to report allegations of abuse to the SA to help keep residents safe. DON stated the facility did not condone abuse, so if it was suspected, it should have been reported. The facility policy titled Vulnerable Adult Abuse And Neglect Prevention revised 10/29/24, identified the purpose was to provide residents a safe environment free from harm. The policy identified all allegations and/or suspicions of abuse must be reported to the Administrator immediately, and if the administrator was not present, the report would be made to the administrator's designee. The facility must report to the SA immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury.	F 609		

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F 610	Continued From page 9	F 610		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit to the State Agency (SA) the results of the investigation within 5 working days for 1 of 3 residents (R4) reviewed for abuse, for 1 of 1 allegations of abuse reviewed. Findings include: R4's quarterly Minimum Data Set (MDS) dated 12/27/24, identified R4 had severe cognitive impairment and diagnoses which included: Alzheimer's disease, anxiety and depression. Indicated R4 had no behaviors and was dependent on staff for transfers, eating, dressing and personal hygiene.	F 610	1. Results of the investigation regarding allegation of abuse for R4 has been submitted to the state agency. 2. All residents have the potential to be affected by this deficient practice. Leadership team has been re-educated regarding timeline for reporting suspicions of abuse through the Abuse policy. 3. Administrator of record at the time of this allegation is no longer employed with the organization. Current Administrator and Director of Nursing educated on facility policy title Vulnerable Adult Abuse and Neglect	1/29/25

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F 610	Continued From page 10 R4's Care Area Assessment (CAA) dated 9/30/24, identified R4 had severe cognitive impairment and was unable to follow a conversation and answer appropriately. R4 had signs of short term memory, and was unable to recall what a daily object was such as a shirt, television, bed or colors. R4 attempted to hit staff while they were completing cares. Staff were unable to redirect R4 when R4 had these behaviors. R4's care plan revised 1/2/25, identified R4 had an activities of daily living (ADL) self-care performance deficit and limited physical mobility with interventions which included: assistance for bathing/showering, dressing, personal hygiene, toilet use, and transfers with two staff and a Hoyer (mechanical) lift. Indicated R4 had impaired cognitive function, and vulnerability of self and or others related to cognitive impairments/dementia, decreased cognition, medical condition/situation. Interventions included to provide safe environment and remove R4 from potentially abusive situations. During an interview on 1/14/25 at 9:39 a.m., NA-C indicated R4 was usually pretty quiet, sang a lot and required total assistance with cares. NA-C stated at times, R4 could become a little resistive to cares. NA-C stated she had reported an allegation of employee to resident abuse to human resource director (HR)-A back in June 2024. NA-C indicated she had reported that trained medication aide (TMA)-A said R4 swatted at her, and she heard TMA-A tell R4 "don't you hit me, do you want me to hit you?" NA-C stated she felt that was emotionally abusive towards R4, and she reported it to HR-A. NA-C stated she was unaware if anything had been done about it,	F 610	Prevention to include ensuring an investigation is completed and an investigation report is turned into the department of health within five working days of the initial report. 4. Audits will be completed twice weekly x 1-month, weekly x 1 month, every other week x 1 month, and monthly x 1 month to ensure all allegations and/or suspicions of abuse are investigated and an investigation report is turned into the department of health within five working days of the initial report. Results and analysis of these audits will be brought to QAPI committee to review and determine frequency of ongoing audits. Responsible person is Administrator and or designee.	

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F 610	Continued From page 11 as TMA-A worked the next day. During an interview on 1/14/25, at 9:56 a.m., HR-A stated the allegation of abuse NA-C had reported sounded vaguely familiar, however could not remember the details or circumstances. HR-A stated her usual process when allegations were reported to her, was to notify the staff member's supervisor, director of nursing (DON) or administrator. HR-A indicated it may have been documented in TMA-A's employee file. HR-A opened TMA-A's file and produced a copy of TMA-A's Employee Counseling Record dated 6/28/24. Review of TMA-A's Employee Counseling Record dated 6/28/24, included the following: -type of notice: coaching and verbal warning were identified by their boxes checked. -detail of description of the problem: It was alleged that staff member yelled at resident, "Do you want me to hit you?" -detailed description of corrective action: When addressing residents staff members must not be verbally abusive. Federal and state law guarantee that certain basic rights to all residents of this facility. You are expected to do Eden Essentials Part 1, due by the end of today, June 28, 2024. -Form signed by employee, DON and HR-A. During an interview on 1/14/25 at 12:10 p.m., DON indicated the allegation of abuse made on 6/28/24, could have been considered abusive, stated the prior administrator was aware and they decided it was not abuse. DON indicated it was important to investigate allegations of abuse to keep residents safe. DON indicated she thought there was a thorough investigation completed by the previous administrator, and thought he would	F 610		

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F 610	Continued From page 12 have kept that. DON indicated she would look for the documention and provide it to surveyor when found. DON confirmed the investigation of the abuse allegation had not been submitted to the SA. Review of the untitled investigation report dated 6/28/24, included a summary of the allegation and findings, interviews with TMA-A, other staff members and residents. The investigation contained a copy of TMA-A's Employee Counseling Record dated 6/28/24, and a staff sign in sheet for education on Abuse Policy Training dated 7/2/24. The facility policy titled Vulnerable Adult Abuse And Neglect Prevention revised 10/29/24, identified it's purpose was to provide residents a safe environment free from harm. The policy identified upon receiving a complaint of alleged maltreatment, the Administrator would be notified immediately, and they, DON or assigned designee, would coordinate an investigation, which would include completion of witness statements-staff, residents or visitors who were potentially involved, or observed the alleged incident were to interviewed by the DON, director of social services, or their designees. All parties involved including two of the following. When a specific staff member was implicated in the alleged event, the person would be removed from the residents care area immediately, interviewed by the supervisor assigned, and asked to provide a written statement and suspend until the investigation was completed. The policy further identified within five business days, an investigation report would be completed and turned in to the department of health and to the facility administrator or designee. The report	F 610		

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F 610	Continued From page 13 woud include details of facility investigation which included a summary of information obtained from interviews of residents, staff and witnesses as appropriate, how had the resident's ability and lifestyle been affected, details of the alleged perpetrator and any action that had been taken to prevent the recurrence of the incident.	F 610		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident call light was within reach for 1 of 4 residents (R3) reviewed for call light accessibility. Findings Include: R3's quarterly Minimum Data Set (MDS) dated 10/25/24, identified R3 was cognitively intact, and had diagnoses which include: anxiety, depression, and asthma (a condition that affects airways and makes breathing difficult). Indicated R3 was dependent on staff for rolling left and right, transfers, dressing and hygiene. R3's Care Area Assessment (CAA) dated 8/23/24, identified R3 had chronic pain related to	F 919	1. R3 was given call light 2. All residents have the potential to be affected by this deficient practice. All residents were observed to ensure all residents had call light accessibility 01/14/2025. 3. Staff have been educated on facility policy titled Call Light Use and Response with emphasis that staff will position the call light conveniently for the residents and within reach at all times, for those residents' needing assistance with call light usage. 4. Audits will be completed twice weekly x	1/29/25

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F 919	Continued From page 14 low back pain, neuropathy (condition that affects the nerves outside brain and spinal cord) and history of fusion of lumbosacral region (surgical joining of vertebrae to the lower back area of spine). R3 took Lyrica (medication used to treat nerve pain) for pain management. R3's care plan revised 10/3/24, identified R3 had an activities of daily living (ADL) self-care performance deficit and limited physical mobility related to fusion of lumbosacral region of the spine, low back pain, neuropathy, abnormalities of gait and mobility, weakness and deconditioning. R3's inventions included: dressing, personal hygiene and bathing assistance of one. Interventions included bed mobility assistance of one, and transfer assistance of two with stand up lift. Identified R3 had chronic pain and the potential for shortness of breath (SOB) while lying flat related to Asthma diagnosis. During an observation on 1/14/25 at 7:53 a.m., R3 was lying in bed, on her right side facing the wall, door open, and lights off. R3 called out, and when surveyor entered the room, R3 stated could not move and wanted to be moved. R3 then indicated was unable to locate her call light. R3's call light was clipped to its cord, attached to the wall, behind the head of R3's bed, out of reach. Surveyor located nursing assistant (NA)-B, who then entered R3's room. NA-B stated she was not sure why R3's call light was attached to the wall, then R3 informed NA-B the night shift had put it up there. R3 informed NA-B she could not breath, wanted to be turned and indicated her hips and thighs were causing her pain. R3's face was red in color. NA-B called on walkie talkie for staff assistance and trained medication aide	F 919	1-month, weekly x 1 month, every other week x 1 month, and monthly x 1 month to ensure all residents needing assistance with call light usage, have a call light within reach. Results and analysis of these audits will be brought to QAPI committee to review and determine frequency of ongoing audits. Responsible person Administrator and or designee	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 15 (TMA)-B entered the room. TMA-B asked R3 how she was and R3 stated she could not breath. TMA-B called for a nurse on her walkie talkie, NAB and TMA-B assisted R3 to reposition to her back, boosted her up in bed, and elevated her head of bed. R3 indicated she felt better, R3's color improved and was pink at that time. During an interview on 1/14/25 at 9:09 a.m.,NA-B stated she was shocked R3's call light was attached to the wall and not placed within her reach. NA-B indicated she felt terrible about that and said at 6:15 a.m. they had made rounds, observed R3 asleep in her bed and did not see where the call light was positioned. NA-B indicated it was important for residents to have their call light so they could call for assistance when needed. During an interview on 1/14/25 at 9:25 a.m., R3 indicated staff sometimes clipped her call light to the wall. R3 stated it caused her trouble that morning, and she thought she had waited about two hours for assistance due to not being able to use the call light. During an interview on 1/14/25 at 10:57 a.m., licensed practical nurse (LPN)-B indicated R3 was able to inform staff what she wanted and her memory was usually intact. LPN-B stated NA-B had informed her that R3 did not have her call light that morning. LPN-B stated it was important to have the call light within reach so the residents could use the call light to alert staff when they needed assistance. During an interview on 1/14/25 at 12:05 p.m., director of nursing (DON) stated her expectation was that residents had their call lights within	F 919		

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	245581	A. BUILDING _____ B. WING _____	C 01/14/2025

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F 919	Continued From page 16 reach at all times. DON indicated staff were expected to check call lights to assure they were within reach when they made their rounds. DON stated it was important for residents to have their call light, for resident safety and dignity. The facility policy titled Call Light Use And Response revised 7/18/23, identified its purpose to respond promptly to resident's call for assistance and to assure call system was in proper working order. The policy identified that staff would position the call light conveniently for the resident and within easy access for use when providing care to the residents. The policy indicated staff were to be sure call lights were placed with reach at all times.	F 919		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/13/25 to 1/14/25, 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 was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H55814620C (MN00109703), H55814641C (MN00104528). AND The following complaints were reviewed. H55814583C (MN00109699), H55814640C (MN00109265), with a licensing order issued at 1805 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. 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	2 000		

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2 000	Continued From page 2 enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 1 of 3 residents (R1) who had unwanted facial hair present, reviewed for dignity. Findings Include: R1's admission Minimum Data Set (MDS) dated 12/17/24, identified R1 was cognitively intact, and had diagnoses which included: hypertension, diabetes mellitus, respiratory failure, and fracture	21805	Corrected	1/29/25

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21805	Continued From page 3 in past six months. Indicated R1 was dependent on staff for transfers, dressing and personal hygiene, which included shaving. R1's Care Area Assessment (CAA) dated 12/20/24, identified R1 had an activities of daily living (ADL) self-care performance deficit related to (r/t) collapsed vertebra, and was working with therapy. Indicated R1's care plan for self-care deficit and impaired physical mobility would be completed. Staff would assist with ADL completion and encourage self-participation. R1's care plan revised 12/30/24, identified R1 had an ADL self-care performance deficit related to collapsed vertebra. R1's interventions included personal hygiene assist of one staff. Review of R1's progress notes from 12/10/24 to 1/13/25, lacked documentation R1 refused to have facial hair removed. During an observation and interview on 1/13/25 at 10:46 a.m., R1 was in his room in a recliner, dressed in street clothes, and family member (FM)-A was present. R1 had a large amount of white facial hair on chin approximately one fourth inch long. R1 indicated it bothered her and staff were to assist her with removing the facial hair. R1 stated staff had not offered to remove her facial hair and she wanted it removed. During an interview on 1/13/25 at 11:06 a.m., nursing assistant (NA)-A, indicated she had not taken care of R1 for a few days, however would have removed R1's facial hair if it was present and visible. At 11:23 a.m. NA-A entered R1's room then after leaving R1's room, confirmed R1 had a large amount of facial hair present and indicated R1 should have been shaven.	21805		

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21805	Continued From page 4 During an observation on 1/13/25 at 11:38 a.m., R1 was in recliner in her room, and facial hair had been removed. R1 rubbed her chin and indicated NA-A had removed her facial hair, which was really nice and she felt better. During an interview on 1/13/25 at 2:42 p.m., licensed practical nurse (LPN)-A stated she was aware R1 needed to have facial hair removed. LPN-A indicated FM-A was going to bring in a new razor for R1, and was unaware if the facility had razors they could use if residents did not have their own. LPN-A stated she expected staff to assist with removing facial hair when observed, had also assisted residents with removing facial hair, and had shaven R1 herself in the past. LPN-A was not aware R1 had ever refused to have facial hair removed. During an interview on 1/13/25 at 3:24 p.m,, director of nursing (DON) confirmed R1 was cognitive and was able to express her needs. DON indicated her expectation was that staff would assist residents to remove unwanted facial hair as it was important for maintaining a resident's dignity. The facility policy titled Activities Of Daily Living (ADLs) dated 3/15/21, identified based on comprehensive assessment of a resident and consistent with the residents's needs and choices, the facility would provide the necessary care and services to ensure that a resident's abilities in activities of daily living did not diminish unless circumstances of the individual's clinical condition demonstrated that such diminution was unavoidable. The policy identified the facility would provide care and services for the following ADLs, which included: hygiene-bathing, dressing,	21805		

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21805	Continued From page 5 grooming, and oral care. ADL cares would be provided based on the resident preferences. If the resident refused care, that would be reported to the nurse and the resident re-approached. Documention of refusal would be completed in the electronic medical record. The facility policy titled Resident Rights: Dignity revised 10/24/23, identified the facility would treat each resident with respect and dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility would protect and promote the rights of the residents. The policy further identified federal and state laws guaranteed certain basic rights to all residents of the facility and these rights included the resident's right to a dignified existence, and to be treated with respect, kindness, and dignity. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity was maintained. The results of these audits could be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		