



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 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 March 6, 2025, we notified you a remedy was imposed. On April 2, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 21, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 12, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 6, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 12, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 21, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

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

April 14, 2025

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

Re: Reinspection Results
Event ID: 2LZ312

Dear Administrator:

On April 2, 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 February 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink 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

March 6, 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 21, 2025, we informed you that we may impose enforcement remedies.

On February 27, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 12, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 12, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 12, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 12, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Fair Oaks Nursing & Rehab LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 12, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 12, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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.

Fair Oaks Nursing & Rehab LLC

March 6, 2025

Page 5

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)

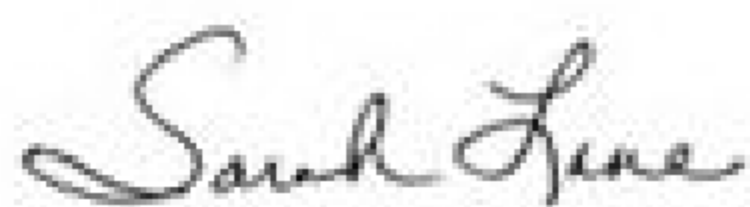
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments 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
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
March 6, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 2LZ311

Dear Administrator:

The above facility was surveyed on February 26, 2025 through February 27, 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.

Fair Oaks Nursing & Rehab LLC

March 6, 2025

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.

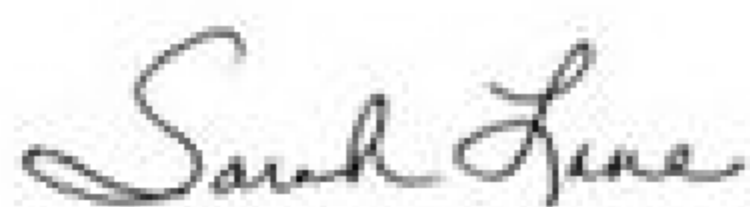
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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 02/27/2025
--	---	--	---

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	<p>INITIAL COMMENTS</p> <p>On 2/26/25 through 2/27/25, 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.</p> <p>The following complaint was reviewed, H55817321C (MN00110528) with a deficiency cited at F689.</p> <p>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.</p> <p>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.</p>	F 000		
F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to demonstrate safe</p>	F 689	<p>1. R1, R2 and R3 care plans reviewed to ensure correct lift and sling size</p>	3/18/25

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

TITLE

(X6) DATE

Electronically Signed

03/14/2025

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: 245581	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025	
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 689	<p>Continued From page 1</p> <p>patient handling to reduce the risk for accidents for 3 of 4 residents (R1, R2, R3) reviewed for safety with mechanical lift assisted transfers.</p> <p>Findings include:</p> <p>R1's Admission Record indicated she admitted to the facility 4/26/24. R1's diagnosis included functional quadriplegia, impaired cognitive function, cognitive communication deficit and weakness.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 12/12/24, identified moderate cognitive impairment and indicated Bilateral upper and lower extremity impairments. The MDS indicated R1 was dependent on staff for transfers.</p> <p>R1's Transfer and Mobility Evaluation dated 2/18/25, indicated the use of a mechanical lift for transfer using an extra-large sling.</p> <p>R1's care plan dated 1/22/25, identified a self-care deficit related to obesity, pain, and weakness. The care plan directed staff to assist with transfers utilizing a mechanical lift and XL sling. The care plan identified a fall from a mechanical lift on 2/5/25.</p> <p>R1's undated Kardex indicated she transferred using a total lift and XL sling.</p> <p>R2's Admission Record indicated she admitted to the facility 1/17/25. R2's diagnosis included polyneuropathy, gait and balance abnormalities, unsteadiness, and muscle weakness.</p> <p>R2's quarterly MDS dated 1/24/25, identified intact cognition and indicated Bilateral lower</p>	F 689	<p>indications.</p> <p>EZ Way Sling Sizing Chart was placed in linen room.</p> <p>2. All residents utilizing lifts are at risk to be affected. All residents care plans reviewed to ensure correct lift and sling size indications.</p> <p>3. All nursing staff educated on the policy and procedure titled Total Mechanical Lift Transfer. All nursing staff will be educated to follow the care plan for correct lift and sling size indications. All nursing staff will be educated on where to find the EZ Way Sling Sizing Chart.</p> <p>4. The facility will audit five total mechanical lift transfers per week for four weeks. Results of audits will be reviewed by the quality compliance committee to ensure compliance and determine the need for ongoing auditing.</p>	

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 02/27/2025
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 689	<p>Continued From page 2</p> <p>extremity impairments. The MDS indicated R2 was dependent on staff for transfers.</p> <p>R2's Transfer and Mobility Evaluation dated 2/20/25, indicated the use of a mechanical lift for transfer using a medium sling.</p> <p>R2's care plan dated 7/5/24, identified a self-care deficit related to spinal fusion, gait abnormalities and weakness. The care plan directed staff to assist with transfers utilizing a mechanical lift and medium sling.</p> <p>R2's undated Kardex indicated transfer using a mechanical lift and medium sling.</p> <p>R3's Admission Record indicated she admitted to the facility 6/14/18. Diagnosis included polyneuropathy, unsteadiness, deformities of foot, stiffness in hands and pain.</p> <p>R3's significant change MDS dated 2/7/25, identified intact cognition and indicated Bilateral upper and lower extremity impairments. The MDS indicated R3 was dependent on staff for transfers.</p> <p>R3's Transfer and Mobility Evaluation dated 11/28/24, indicated the use of a mechanical lift for transfer using an extra-large sling.</p> <p>R3's care plan dated 2/19/25, identified limited physical mobility related to muscle weakness, deformities of foot and fibromyalgia. The care plan directed staff to assist with transfers utilizing a mechanical lift and large sling.</p> <p>R3's undated Kardex indicated R3 transferred with a mechanical lift and large sling.</p>	F 689		

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 02/27/2025
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 689	<p>Continued From page 3</p> <p>An EZ Way Sling Sizing Chart for use with EZ Way mechanical lift device identified the following color-coding system: -Gray - small, 70-100 pounds (lbs.) -Beige- Medium, 91-220 lbs. -Burgundy- Large, 190-320 lbs. -Green- Extra-large (XL) - 280-450 lbs. -Black- XXL- 400-600 lbs. -Brown- XXXL- 600 + lbs. -Color coding was used on the binding of the slings.</p> <p>During observation on 2/26/25 at 1:19 p.m., nursing assistants (NA)-A and NA-B transferred R1 using a mechanical lift. The sling used to transfer R1 had a beige binding which indicated a medium sling. R2 was seated in a wheelchair in the room with a sling underneath her. NA-A and NA-B transferred R2 using the mechanical lift and the sling with beige binding which indicated a medium sling.</p> <p>During observation on 2/26/25 at 4:59 p.m., NA-C and NA-D prepared to transfer R3 in a mechanical lift using a sling with split legs. As the lift started to rise, R3 stopped the NA's and said the leg straps were not crossed. NA-C stated, "I did it again."</p> <p>During observation on 2/27/25, at 9:11 a.m., R1 and R2 were in bed. R1 had a sling underneath her in the bed that had a burgundy binding which indicated a large sling.</p> <p>During observation and interview on 2/27/25 at 8:59 a.m. R3 stated she had stopped the transfer the previous evening because the legs of the sling should have been criss/crossed and they</p>	F 689		

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 02/27/2025
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 689	<p>Continued From page 4</p> <p>were not. R3 stated one time she had almost fallen through the sling as it was in the air because of the same thing. R3 stated she had to remind the staff frequently to cross the straps between her legs. R3 further stated, a few weeks before, staff had put her in her recliner and started to pull the lift from the room without unhooking the straps causing her to pull her whole body forward. R3 was seated in a wheelchair on top of a large sling.</p> <p>During interview on 2/27/25 at 9:22 a.m., NA-A stated the residents did not have their own slings. NA-A stated sling size depended on the residents weight. NA-A stated she did not know where to find the sizing guide and said she just guessed the size based on her experience and said there was not anything that told them what size to use.</p> <p>During interview on 2/27/25 at 9:31 a.m., NA-E stated the sling size should be in the care plan and was based on the residents weight. NA-E said, staff just knew what size to use. NA-F was also present and said there used to be a chart on the wall in the linen room but was not there anymore. NA-F stated, "when you have been here long enough, you know what size."</p> <p>During observation with NA-B on 2/27/25 at 9:37 a.m., NA-B confirmed both R1 and R2 currently had large slings under them and confirmed both R1 and R2 had been transferred using medium slings the previous day.</p> <p>During interview on 2/27/25 at 9:56 a.m. the director of nursing (DON) stated residents were assessed for sling size on admission. The DON said residents do not have their own dedicated slings and said the size was listed on the Kardex</p>	F 689		

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 02/27/2025
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 689	<p>Continued From page 5</p> <p>and said they could also go by the color of the sling. At 11:46 a.m., the DON stated lift training were completed on the computer and in person training as well as with their mentor during orientation.</p> <p>Facility policy and procedure Total Mechanical Transfer dated 8/1/15, indicated to safely transfer residents who have been assessed per the safe patient handling program to requires the use of a total lift. The procedure directed staff to assemble the needed supplies, including the sling. The policy did not include identification of the appropriate sling and/or sling size.</p> <p>Facility Provided checklist titled United Heartland Total Lift, dated 8/2016, indicated; brings equipment to the bedside. Uses the proper size sling for the resident.</p>	F 689		

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 02/27/2025
--	--	---	--

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 style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">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 2/26/25 through 2/27/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders</p>	2 000		
-------	---	-------	--	--

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

03/14/25

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 02/27/2025
--	--	---	---

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>and identify the date when they will be completed.</p> <p>The following complaints were reviewed: H55817321C (MN00110528) with a licensing order issued at 0830.</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 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</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 02/27/2025
--	--	---	--

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 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to demonstrate safe patient handling to reduce the risk for accidents for 3 of 4 residents (R1, R2, R3) reviewed for safety with mechanical lift assisted transfers. Findings include: R1's Admission Record indicated she admitted to the facility 4/26/24. R1's diagnosis included functional quadriplegia, impaired cognitive	2 830	Corrected	3/18/25

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 02/27/2025
--	--	---	--

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
2 830	<p>Continued From page 3</p> <p>function, cognitive communication deficit and weakness.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 12/12/24, identified moderate cognitive impairment and indicated Bilateral upper and lower extremity impairments. The MDS indicated R1 was dependent on staff for transfers.</p> <p>R1's Transfer and Mobility Evaluation dated 2/18/25, indicated the use of a mechanical lift for transfer using an extra-large sling.</p> <p>R1's care plan dated 1/22/25, identified a self-care deficit related to obesity, pain, and weakness. The care plan directed staff to assist with transfers utilizing a mechanical lift and XL sling. The care plan identified a fall from a mechanical lift on 2/5/25.</p> <p>R1's undated Kardex indicated she transferred using a total lift and XL sling.</p> <p>R2's Admission Record indicated she admitted to the facility 1/17/25. R2's diagnosis included polyneuropathy, gait and balance abnormalities, unsteadiness, and muscle weakness.</p> <p>R2's quarterly MDS dated 1/24/25, identified intact cognition and indicated Bilateral lower extremity impairments. The MDS indicated R2 was dependent on staff for transfers.</p> <p>R2's Transfer and Mobility Evaluation dated 2/20/25, indicated the use of a mechanical lift for transfer using a medium sling.</p> <p>R2's care plan dated 7/5/24, identified a self-care deficit related to spinal fusion, gait abnormalities and weakness. The care plan directed staff to</p>	2 830		

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 02/27/2025
--	--	---	--

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
2 830	<p>Continued From page 4</p> <p>assist with transfers utilizing a mechanical lift and medium sling.</p> <p>R2's undated Kardex indicated transfer using a mechanical lift and medium sling.</p> <p>R3's Admission Record indicated she admitted to the facility 6/14/18. Diagnosis included polyneuropathy, unsteadiness, deformities of foot, stiffness in hands and pain.</p> <p>R3's significant change MDS dated 2/7/25, identified intact cognition and indicated Bilateral upper and lower extremity impairments. The MDS indicated R3 was dependent on staff for transfers.</p> <p>R3's Transfer and Mobility Evaluation dated 11/28/24, indicated the use of a mechanical lift for transfer using an extra-large sling.</p> <p>R3's care plan dated 2/19/25, identified limited physical mobility related to muscle weakness, deformities of foot and fibromyalgia. The care plan directed staff to assist with transfers utilizing a mechanical lift and large sling.</p> <p>R3's undated Kardex indicated R3 transferred with a mechanical lift and large sling.</p> <p>An EZ Way Sling Sizing Chart for use with EZ Way mechanical lift device identified the following color-coding system: -Gray - small, 70-100 pounds (lbs.) -Beige- Medium, 91-220 lbs. -Burgundy- Large, 190-320 lbs. -Green- Extra-large (XL) - 280-450 lbs. -Black- XXL- 400-600 lbs. -Brown- XXXL- 600 + lbs. -Color coding was used on the binding of the</p>	2 830		

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 02/27/2025
--	--	---	--

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
2 830	<p>Continued From page 5</p> <p>slings.</p> <p>During observation on 2/26/25 at 1:19 p.m., nursing assistants (NA)-A and NA-B transferred R1 using a mechanical lift. The sling used to transfer R1 had a beige binding which indicated a medium sling. R2 was seated in a wheelchair in the room with a sling underneath her. NA-A and NA-B transferred R2 using the mechanical lift and the sling with beige binding which indicated a medium sling.</p> <p>During observation on 2/26/25 at 4:59 p.m., NA-C and NA-D prepared to transfer R3 in a mechanical lift using a sling with split legs. As the lift started to rise, R3 stopped the NA's and said the leg straps were not crossed. NA-C stated, "I did it again."</p> <p>During observation on 2/27/25, at 9:11 a.m., R1 and R2 were in bed. R1 had a sling underneath her in the bed that had a burgundy binding which indicated a large sling.</p> <p>During observation and interview on 2/27/25 at 8:59 a.m. R3 stated she had stopped the transfer the previous evening because the legs of the sling should have been criss/crossed and they were not. R3 stated one time she had almost fallen through the sling as it was in the air because of the same thing. R3 stated she had to remind the staff frequently to cross the straps between her legs. R3 further stated, a few weeks before, staff had put her in her recliner and started to pull the lift from the room without unhooking the straps causing her to pull her whole body forward. R3 was seated in a wheelchair on top of a large sling.</p> <p>During interview on 2/27/25 at 9:22 a.m., NA-A</p>	2 830		

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 02/27/2025
--	--	---	--

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
2 830	<p>Continued From page 6</p> <p>stated the residents did not have their own slings. NA-A stated sling size depended on the residents weight. NA-A stated she did not know where to find the sizing guide and said she just guessed the size based on her experience and said there was not anything that told them what size to use.</p> <p>During interview on 2/27/25 at 9:31 a.m., NA-E stated the sling size should be in the care plan and was based on the residents weight. NA-E said, staff just knew what size to use. NA-F was also present and said there used to be a chart on the wall in the linen room but was not there anymore. NA-F stated, "when you have been here long enough, you know what size."</p> <p>During observation with NA-B on 2/27/25 at 9:37 a.m., NA-B confirmed both R1 and R2 currently had large slings under them and confirmed both R1 and R2 had been transferred using medium slings the previous day.</p> <p>During interview on 2/27/25 at 9:56 a.m. the director of nursing (DON) stated residents were assessed for sling size on admission. The DON said residents do not have their own dedicated slings and said the size was listed on the Kardex and said they could also go by the color of the sling. At 11:46 a.m., the DON stated lift training were completed on the computer and in person training as well as with their mentor during orientation.</p> <p>Facility policy and procedure Total Mechanical Transfer dated 8/1/15, indicated to safely transfer residents who have been assessed per the safe patient handling program to requires the use of a total lift. The procedure directed staff to assemble the needed supplies, including the sling. The policy did not include identification of the</p>	2 830		

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 02/27/2025
--	--	---	--

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
2 830	<p>Continued From page 7</p> <p>appropriate sling and/or sling size.</p> <p>Facility Provided checklist titled United Heartland Total Lift, dated 8/2016, indicated; brings equipment to the bedside. Uses the proper size sling for the resident.</p> <p>SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure staff are appropriately trained to operate mechanical lifts according to manufacturer's instructions. The facility should ensure lift manuals are easily accessible and staff are deemed competent to operators instructions. The director of nursing or designee, should conduct audits of the delivery of care with lift use and competencies are performed. The results of those audits should be taken to QAPI to determine compliance or the need for ongoing monitoring.</p> <p>TIMEFRAME FOR CORRECTION: Twenty-One (21) days.</p>	2 830		