



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
July 3, 2025

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

RE: CCN: 245581  
Cycle Start Date: June 20, 2025

Dear Administrator:

On June 20, 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 immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

#### REMOVAL OF IMMEDIATE JEOPARDY

On June 12, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervisor/Devices was removed.

#### 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 listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

#### SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have

Fair Oaks Nursing & Rehab LLC

July 3, 2025

Page 2

received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Fair Oaks Nursing & Rehab LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 20, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

#### 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:

Susie Haben, Regional Operations Supervisor RR  
Health Regulation Division  
Minnesota Department of Health  
4140 Thielman Lane  
Saint Cloud, Minnesota 56301-4557  
Email: susie.haben@state.mn.us  
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Fair Oaks Nursing & Rehab LLC

July 3, 2025

Page 3

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](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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



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July 3, 2025

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

Re: Event ID: L8K811

Dear Administrator:

The above facility survey was completed on June 20, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

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

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

PRINTED: 07/03/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245581</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>FAIR OAKS NURSING &amp; REHAB LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 SHADY LANE DRIVE</b> <b>WADENA, MN 56482</b>		
(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 6/17/25 through 6/18/25 and 6/20/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.  The following complaint was reviewed H55817072C (MN00113835) and a deficiency was issued at an immediate jeopardy (F689) at PAST NON-COMPLIANCE.  The following complaints were reviewed with no deficiencies: H55816429C (MN00113608) H55817647C (MN00110921)  Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §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  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689			

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

TITLE

(X6) DATE

Electronically Signed

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

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F 689	<p>Continued From page 1</p> <p>Based on observation, interview and document review the facility failed to ensure safe transport with a facility van for 1 of 3 residents (R1). This resulted in an immediate jeopardy (IJ) for R1 when she slid out of wheelchair during transport, resulting in fractures.</p> <p>The immediate jeopardy (IJ) began on 6/11/25, at approximately 10:00 a.m., when the transport driver (TD) transported R1 in the facility van without the use of a seatbelt. R1 slid out of her wheelchair during transport resulting in closed fractures to the right and left tibias (the larger bone of the lower leg) and closed fracture of left femur (the main bone in your thigh that connects your hip to your knee and is your body's largest and strongest bone). The IJ was identified on 6/18/25, the administrator was notified of the IJ on 6/18/25, at 1:32 p.m. The IJ was removed on 6/12/25, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance.</p> <p>Findings include:</p> <p>R1's Admission Record indicated she admitted to the facility 12/2/2004. R1's diagnosis included anxiety, morbid obesity and muscle weakness.</p> <p>R1's annual Minimum Data Set (MDS) dated 5/13/25, identified severe cognitive impairment and indicated she had upper and lower extremity impairments on both sides. The MDS indicated R1 was dependent on staff for all activities of daily living including wheelchair mobility.</p> <p>R1's care plan revised 6/17/25, identified a low risk for falls as she was dependent on staff for significant movements. Potential for falls due to</p>	F 689	Past noncompliance: no plan of correction required.	

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F 689	<p>Continued From page 2</p> <p>staff error during positioning/transfers. R1 had an actual fall during transport 6/11/25, with injuries. The care plan indicated R1 must be transported by stretcher for out of town appointments and may use local transport for in town appointments.</p> <p>A facility Incident Summary indicated on 6/11/25, during routine transport, R1 was transported in the facility van in a wheelchair. Due to R1's size, the driver was unable to secure the seatbelt. Based on prior guidance from a former administrator, the driver believed that securing only the wheelchair was sufficient for safety. While in transport, R1 began sliding from her wheelchair and ultimately ended up on the floor of the van. The driver immediately stopped the van and contacted emergency services. R1 was transported the Emergency Department (ED) for further evaluation. Initial medical evaluation did not identify any injuries and R1 returned to the facility. Driver received immediate education regarding facility transportation safety policy which mandated the use of appropriate restraints for all residents during transport.</p> <p>R1' facility Progress Notes indicated the following:</p> <p>6/11/25, R1 returned from hospital via ambulance. R1 returned with a new order for Hydrocodone-Acetaminophen 5 milligrams(mg)-325 mg to be given as needed every six hours for pain.</p> <p>6/13/25, R1 reported pain in both hips rated 10/10 on pain scale.</p> <p>6/14/25, R1 had pain on outer side of right leg when rolling in bed and transferring into wheelchair.</p>	F 689		

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F 689	<p>Continued From page 3</p> <p>6/15/25, R1 had outer right leg pain when rolling and being lifted into chair.</p> <p>6/15/25, R1 had a "greenish" bruise on her right leg below the knee with pooling color going towards inner right leg. The same area the pain was in. The bruise was first noticed on the p.m. shift on 6/14/25.</p> <p>6/16/25, R1 continued to have complaints of pain in legs and yelled out when being moved. R1 to be sent by ambulance to the emergency department (ED).</p> <p>6/16/25, R1 returned from the ED with diagnosis of closed fracture of medial portion of right and left tibia and closed fracture of left femur. New order for Hydrocodone-Acetaminophen 5-325 mg, 1 tablet every four hours as needed for pain. R1 returned with knee immobilizers to right and left lower extremities.</p> <p>R1's ED notes dated 6/16/25, indicated diagnosis of closed fracture of medial portion of right tibial plateau, initial encounter. Chief complaint: extremity pain. The notes indicated R1 admitted from nursing home with right lower leg and bilateral hip pain. R1 was paraplegic, was in a wheelchair last week and fell out onto the floor and has had increased pain in the hips since. Today at the nursing home she was having pain again and staff noticed bruising about the proximal right lower leg which had not previously been x-rayed.</p> <p>On 6/17/25 at 1:37 p.m., R1 was interviewed along with family member (FM)-A. FM-A stated the day of the incident, she had been told the TD</p>	F 689		

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F 689	<p>Continued From page 4</p> <p>had secured the chair to the floor but had not placed a seat belt around R1. R1 stated she remembered the fall and pointed to the floor with her finger and said "boom." When asked if she had been injured R1 stated, "oh yeah." FM-A identified after the incident, R1 went to the clinic near where the incident had occurred where they did only a hip x-ray. FM-A stated R1 went to the ED the previous day and both of her legs were fractured; adding; she knew on the 12th that something was wrong because R1 was in so much pain when transferred in the lift.</p> <p>During interview on 6/17/25 at 1:58 p.m., the director of nursing (DON) stated the TD was the only person who drove the van. She added, she was not aware of any training completed when the TD was hired but said he was educated on the transport policy after the incident.</p> <p>During interview on 6/17/25 at 2:37 p.m., the TD stated he had been driving for the facility since February of 2024. The TD stated he remembered a lot of "policy stuff" the first few days but did not remember receiving any education specific to the transport of residents. He stated on 6/11/25, R1 had an appointment in the cities and said when he went to load her into the van, he "wasn't very optimistic." The TD stated the wheelchair was very big and unless the chair was smaller it was hard to get the chair positioned facing forward. The TD said the ideal position in the van was to face the person forward, connect the straps to the wheelchair and place the seatbelt on the resident. He revealed he was not able to get the seatbelt on R1 and was unable to tilt the chair back. The TD stated while on the highway, R1 was asleep then suddenly yelled out as if she were startled and she slid forward out of the chair. The TD</p>	F 689		

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F 689	<p>Continued From page 5</p> <p>stated he could hear the concern in R1's voice so he pulled over, R1 was still in motion so he tried to block her from falling to the floor. TD added, in hindsight he should not have transported R1 without a seat belt, received education and training after the incident and was the DON had been auditing as he loaded residents into the van.</p> <p>During observation on 6/17/25 at 2:50 p.m., R1 was transferred from wheelchair to bed using a total body lift. During the transfer, R1 was saying, "it burns, I can't stand it." R1 displayed facial grimacing and said "ayy, yaay, yaay, ouch." R1's legs were wrapped from ankle to mid-thigh in immobilizers.</p> <p>During interview on 6/18/25 at 10:06 a.m., the human resources director stated she had worked at the facility for four years and had never provided any policies, procedures or training related to transporting residents in the facility van.</p> <p>Facility policy, Transport Driver Policies and Forms dated September 2023, indicated; ensure all residents and wheelchairs are safely secured.</p> <p>Facility Transportation Driver Job Summary, September 2023, indicated; transports residents to and from appointments in a safe and responsible manner.</p> <p>The past noncompliance immediate jeopardy began on 6/11/25. The immediate jeopardy was removed 6/12/25, and the deficient practice corrected after the facility implemented a systemic plan that included the following actions:</p> <ul style="list-style-type: none"> <li>- Implemented education and audits for safe transport for the TD.</li> <li>- The administrator and human resources director</li> </ul>	F 689		

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F 689	Continued From page 6 received education on training and polices to be completed upon hire of anyone transporting residents in the facility van. - Education and audits were verified through interview and document review.	F 689			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00679</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FAIR OAKS NURSING &amp; REHAB LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 SHADY LANE DRIVE WADENA, MN 56482</b>
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></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 6/17/25 through 6/18/25 and 6/20/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H55817072C (MN00113835)</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00679</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2025</b>
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2 000	<p>Continued From page 1</p> <p>H55816429C (MN00113608) H55817647C (MN00110921) NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		