DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 31, 2022

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

RE: CCN: 245581
Cycle Start Date: March 31, 2022

Dear Administrator:

On April 18, 2022, we notified you a remedy was imposed. On May 17, 2022 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 May 9, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 1, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 18, 2022, 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 July 1, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 9, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.
Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

May 31, 2022

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

Re: Reinspection Results
Event ID: 06P712

Dear Administrator:

On May 17, 2022 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 May 17, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
April 18, 2022

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

RE: CCN: 245581
Cycle Start Date: March 31, 2022

Dear Administrator:

On March 31, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 1, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2022.

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.

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

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 $11,292; 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 July 1, 2022, 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 July 1, 2022. 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 September 30, 2022 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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	C 03/31/2022

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
E 000	Initial Comments On 3/28/22, to 3/31/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/28/22, to 3/31/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5581067C (MN80810 and MN80869), H5581068C (MN79311). 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2022

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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		5/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 2 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 3 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and review, the facility failed to notify the State Ombudsman's office of a facility transfer for one of two residents (R8) reviewed for transfers. Findings include: Review of the R8's form titled Face Sheet revealed R8 was admitted to the facility on 7/23/21, and readmitted on 1/31/22. Review of R8's progress notes from 1/30/22, to 1/31/22, revealed the following: -1/30/22, at 2:50 p.m. identified the ambulance arrived at the facility and transported R8 to the emergency room due to R8's altered cognition. -1/31/22, at 6:50 p.m. R8 had been re-admitted to the hospital. Review of the Ombudsman notifications for the month of January and February 2022, revealed	F 623	F623- D Notice Requirements Before Transfer/Discharge The facility failed to notify the Ombudsman of a facility transfer for one resident who was hospitalized but returned to the facility. 1. F623 2. The ombudsman was notified of the resident□s transfer to the hospital (1/30/22) and readmission to FOL (1/31/22) on 3/30/22. All residents who have been transferred within the last three months were reviewed to ensure that notifications were sent to the Ombudsman timely. 3. All residents are at risk of being affected by this deficient practice. 4. Education provided to nursing staff and social services designee related to the procedure of transferring a resident	

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F 623	Continued From page 4 no documentation the Ombudsman had been notified about R8's transfer to the hospital. During an interview on 3/30/22, at 3:10 p.m., the Social Service Director (SSD) indicated the process for notification of the Ombudsman was to fax, at the beginning of the month, a list of residents transferred or discharged from the facility during the previous month. SSD confirmed review of the notifications for the month of January 2022, and February 2022, revealed the Ombudsman had been notified that R8 was transferred to the hospital. During an interview on 3/30/22, at 3:15 p.m., the Minimum Data Set (MDS) Coordinator confirmed R8 was discharged from the facility on 1/30/22, at 2:50 p.m. and returned to the facility the next day, on 1/31/22, at 6:40 p.m. During an interview on 3/30/22, at 3:20 p.m., the administrator stated the expectation was staff were to fax the Ombudsman the list of residents discharged on a monthly basis even if the resident had only been gone for one day. The administrator confirmed the notification of the discharge of R8 on 1/30/22, had not been communicated to the Ombudsman. Review of the facility policy titled Admission, Readmission, Bed Hold, and Transfer/Discharge dated 1/04/19, revealed a copy of the [discharge] notice must be sent to a representative of the Office of the State Long-Term Care Ombudsman.	F 623	out of point click care when he or she is sent to the hospital and sending the proper notification to the Ombudsman. 5. Audits initiated 4/21/22 to be completed and audited by the DON or designee two times weekly for four weeks, then every week for four weeks. Audits will be reviewed at QAPI for additional oversight and possible changes needed to ensure ongoing compliance. 6. DON/designee will be responsible for compliance. 7. This deficiency will be corrected 5/9/22.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		5/9/22

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F 655	Continued From page 5 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655		

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F 655	Continued From page 6 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a baseline care plan was completed within 48-hours of admission for one of four residents (R) 245 reviewed for baseline care plans. Findings include: Review of R245's face sheet revealed R245 was admitted to the facility on 3/25/22, with diagnoses which included sepsis (infection causing tissue injury), osteomyelitis (infection of the bone) of the right ankle, and a chronic ulcer to the lower left leg. Review of R245's baseline care plan identified the first two sections, General Information and Functional Status were completed on 3/25/22. The following six sections, Health Conditions, Dietary, Therapy, Social Services, Activities, and Baseline Care Plan (BCP) Summary and Signatures had not been completed. Additionally, the form lacked signatures from the resident and or family representative. During an interview on 3/31/22, at 9:50 a.m., the assistant director of nursing (ADON) stated staff were expected to complete the baseline care plans within 48-hours of admission. ADON confirmed R245's baseline care plan had not been completed. Review of the facility policy titled Care Plan-Baseline and Comprehensive, revised	F 655	F655- D Baseline Care Plan Facility failed to ensure a baseline care plan was completed within 48 hours of admission for one resident. 1. F655 2. Baseline care plan for R 245 completed 3/29/22. All residents who have admitted within the last week were reviewed to ensure that his or her baseline care plans have been completed timely. 3. All residents are at risk of being affected by this deficient practice. 4. Education provided to nursing staff, social services designee, therapy director, activity director and dietary manager related to timely completion of the baseline care plan upon admit. 5. Audits initiated 4/21/22 to be completed and audited by the DON or designee one time weekly for four weeks, then every other week for one month. Audits will be reviewed at QAPI for additional oversight and possible changes needed to ensure ongoing compliance. 6. DON/designee will be responsible for compliance. 7. This deficiency will be corrected 5/9/22.	

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F 655	Continued From page 7 2/12/22, revealed a baseline care plan would be developed within 48 hours of admission.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance with routine grooming which included facial hair removal for 2 of 2 residents (R17 and R30) who required assistance with grooming and personal hygiene. Findings include: R17's quarterly Minimum Data Set (MDS) dated 2/10/22, identified R17 had diagnoses which included dementia, depression, and end stage renal disease. The MDS identified R17 had severe cognitive impairment, required extensive assistance with personal hygiene and was totally dependent for activities of daily living (ADL's) of dressing and bathing. The MDS revealed R17 had no rejection of cares during the seven day look back period. R17's care plan revised 1/26/22, identified R17 had an ADL deficit, required assistance with dressing, bathing and personal hygiene. R17's care plan directed facility staff to check nail length and to attempt to trim and clean on bath day, as necessary and preferred to have long nails. R17's care plan lacked direction and preferences for	F 677	F677- D ADL Care Provided for Dependent Residents Facility failed to provide assistance with routine grooming which included facial hair removal for two residents who required assistance with grooming and personal hygiene. 1. F667 2. Facial hair was shaved, and fingernails were cleansed and trimmed for R17 and R30. All other residents assessed for shaving needs and shaved as required. All residents are at risk of being affected by this deficient practice. 3. All residents are at risk of being affected by this deficient practice. 4. Education provided to nursing staff and activity staff related to the importance of shaving per resident□s needs or desires. 5. Audits initiated 4/21/22 to be completed and audited by the DON or designee three times weekly for four weeks, then weekly for one month. Audits will be reviewed at QAPI for review. The audits determine whether the resident	5/9/22

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F 677	Continued From page 8 facial hair removal. On 3/28/22, at 4:48 p.m. R17 was observed laying on her back in bed, eyes were closed, covered with a blanket from her feet to upper chest. R17 had several dozen, approximately five (5) to seven (7) millimeters (mm) long, white, wispy chin hairs and several dozen, two (2) to three (3) mm long, thick, course black hair along her chin, upper lip and corners of her mouth. On 3/29/22, at 9:45 a.m. R17 was observed seated in a tilt in space wheelchair (specialized wheelchair for positioning) in her room with her eyes closed. R17 faced the doorway, she had an over the bed, rolling table placed in front of her. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's hands rested on her lap, all ten of her fingernails were approximately 2-3 mm of length, were jagged, had chipped mauve colored nail polish and were observed to have a thick brownish substance underneath the length of all ten of her fingernails. - at 2:38 p.m. during an observation, R17 was laying on her back in bed, covered with a blue blanket up to her chin. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's hands rested on her chest, all ten of her fingernails were approximately 2-3 mm of length, were jagged, had chipped mauve colored nail polish and were observed to have a thick brownish substance underneath the length of all ten of her fingernails.	F 677	was shaved, if they refused to shave, and if their care plan was updated to reflect his or her preference in shaving, if different than every day. 6. DON/designee will be responsible for compliance. 7. This deficiency will be corrected 5/9/22.	

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F 677	Continued From page 9 On 3/30/22, at 8:14 a.m. during an observation, R17 was laying in bed on her back, eyes were closed and was covered with a blanket from her feet to her chin. At that time, nursing assistant (NA)-E and NA-C, entered R17's room and proceeded to assist R17 with morning cares. R17 was assisted from her bed to a tilt in space wheelchair, NA-E proceeded to brush R17's hair. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. - at 9:46 a.m. during an observation, R17 remained seated in a tilt in space chair in her room with an over the bed table in front of her. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. - at 11:51 a.m. during an observation, R17 was seated in a tilt in space chair in her room, positioned to face the doorway. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails.	F 677		

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F 677	Continued From page 10 On 3/30/22, at 8:43 a.m. during an interview, NA-E indicated R17 was totally dependent for all ADL's, which included dressing, personal hygiene and bathing. NA-E indicated he did not feel R17 was able to verbalize her needs or wishes and staff were to anticipate her needs. NA-E stated he did not offer to remove R17's facial hair and did not attempt to provide nail care. NA-E indicated he was not aware of R17's preferences regarding facial hair removal and was not sure who was responsible for R17's nail care. On 3/30/22, at 12:37 p.m. during an interview, NA-C stated R17 was totally dependent for all of her ADL's of dressing, bathing, personal hygiene and all mobility. NA-C confirmed R17 was not offered to have her facial hair removed during morning cares and had not been offered since. NA-C indicated R17's nail were cleaned and filed on her bath day and as needed by other staff. NA-C stated she was not sure what the brown substance was underneath R17's nails and indicated she was not sure how long the substance had been underneath R17's fingernails. On 3/30/22, at 12:53 p.m. during an interview, licensed practical nurse (LPN)-B confirmed R17 had dozens of 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. LPN-B also confirmed R17's fingernails were jagged, and had a thick brownish substance underneath the length of all ten fingernails. LPN-B stated she felt it would be important to R17 to be shaved daily and to have her nails, neatly painted and filed. LPN-B indicated R17 used to take pride in her appearance prior to her dementia diagnosis.	F 677		

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F 677	Continued From page 11 On 3/31/22, at 8:37 a.m. during an interview the assistant director of nursing (ADON) stated she felt R17 did not like anyone to touch her fingernails, preferred them long and felt it was difficult to keep her nails well manicured. The ADON stated she felt R17 likely had refused to have her facial hair removed, indicated the facility activity staff had been assisting with resident cares such as nail care, facial hair removal and other grooming and felt they were not aware of how to document resident refusals. The ADON stated she would expect R17 to be offered to shave daily and have her nail care provided as she would allow. On 3/31/22, at 9:23 a.m. during a telephone interview, R17's family member (FM)-A stated prior to R17's dementia diagnosis, she had taken pride in her overall appearance and had well manicured fingernails. FM-A indicated he had spoken to facility staff in the past year about concerns with R17's facial hair, nails and overall appearance. FM-A stated he expected R17 be assisted to remove her facial hair and be well groomed on a daily basis. On 3/31/22, at 9:27 a.m. during an interview, activity director (AD)-A stated R17 had been offered nail care and shaving on Monday, 3/28/22, and had refused. AD-A indicated she was unaware if R17 had been offered assistance with shaving or nail care on any days following her refusal. AD-A stated R17 had been assisted with shaving following interview with nursing staff on 3/30/22. R30	F 677		

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F 677	Continued From page 12 R30's quarterly Minimum Data Set (MDS) dated 3/3/22, identified R30 had diagnoses which included dementia, anxiety and bilateral above the knee amputations. The MDS identified R30 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene and was totally dependent for bathing. The MDS identified R30 had no rejection of cares during the assessment period. R30's care plan revised 3/24/22, revealed R30 had an ADL self care deficit, required assistance with dressing, bathing, and personal hygiene. The care plan did not identify R30's facial hair or shaving preferences. On 3/28/22, at 5:12 p.m. during a telephone interview, R30's family member (FM)-B stated R30 liked to have a neat, clean appearance and would shave his facial hair daily. FM-B indicated R30 had a mustache oftentimes in the past, but did not have a beard, and liked to be clean shaven. FM-B indicated, a few months prior, R30's wife had voiced concerns about R30's appearance. She indicated R30's hair was unkept, he was unshaven and overall messy in appearance. FM-B indicated she had spoken to nursing and had not seen or heard any further concerns regarding R30's appearance since then. On 3/28/22, at 5:18 p.m. R30 was observed laying in bed on his back, his eyes closed and was covered with a blanket from his lower extremities up to his mid chest. R30's beard line was covered with thick, course, white/gray stubble approximately two (2) to three (3) millimeter (mm) long, along his cheeks, chin, neck and upper lip.	F 677		

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F 677	Continued From page 13 On 3/29/22, at 10:51 a.m. R30 was observed laying in bed on his back in a low bed, eyes closed and was covered with a blanket up to the top of his chest. R30 continued to have thick, course, white/gray facial stubble, approximately 2-3 mm long, along his cheeks, chin, neck and around his mouth. -at 3:46 p.m. R30 was observed seated in a tilt in space chair in his room and faced the window. R30 continued to have thick, course, white/gray facial stubble, approximately 2-3 mm long, along his cheeks, chin, neck and around his mouth. On 3/30/22, at 7:34 a.m. R30 was observed laying in his bed, on his back, eyes were closed and was covered with a blanket up to the top of his chest. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to four (4) mm long, along his cheeks, chin, neck and around his mouth. -at 11:44 a.m. R30 was observed seated in a tilt in space chair in the common area of the unit. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to 4 mm long, along his cheeks, chin, neck and around his mouth. - at 2:22 p.m. R30 was observed laying in bed on his back, his eyes were opened, he was covered with a blanket up to his chin. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to four (4) mm long, along his cheeks, chin, neck and around his mouth. On 3/30/22, at 2:23 p.m. nursing assistant (NA)-E stated R30 was totally dependent for all ADL's,	F 677		

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F 677	Continued From page 14 which included dressing, personal hygiene and bathing. NA-E indicated R30 was shaved twice weekly and he had not shaved R30 in the past couple of days. On 3/30/22, at 2:40 p.m. licensed practical nurse (LPN)-A confirmed R30's facial hair, indicated it appeared R30 had not been shaved for a few days. LPN-A indicated R30 preferred to be clean shaven and should have been shaved daily. On 3/31/22, at 8:46 p.m. the facility administrator stated she felt R30 had refused shaving and routinely refused cares. The administrator indicated R30 historically was verbally aggressive with staff and could be very difficult to work with. She indicated she was not aware if staff were documenting R30's refusals, though would expect staff to document all refusals of care. On 3/31/22, at 9:30 a.m. the activity director (AD)-A stated R30 was approached on Monday, 3/28/22, and was offered shaving at that time. The AD-A indicated she was not aware if R30 had been offered to shave any other days during the week, but felt staff would assist if he allowed. A facility policy titled, Activities of Daily Living (ADL's) revised 3/15/21, identified based on assessment and resident needs and choices, the facility must provide the necessary care and services. The policy revealed the facility would provide the following ADL's, which included hygiene of bathing, dressing, grooming and oral cares.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		5/9/22

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F 695	Continued From page 15 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to obtain a physician's order for Continuous Positive Airway Pressure (CPAP) (delivers oxygenated air into the airways through a mask and a tube) therapy for one of four residents (R24) reviewed for respiratory care. Findings include: Review of R24's significant change Minimum Data Set (MDS) dated of 2/28/22, identified R24 was admitted on 12/21/21, was cognitively intact, and used a CPAP. Review of R24's face sheet dated 3/14/22 identified R24 had a diagnosis of obstructive sleep apnea (sleep disorder where breathing repeatedly stops and starts). Review of R24's physician orders in the electronic health record (EHR) identified an order for a CPAP on while sleeping and at bedtime with at home settings was obtained on 3/31/22. The EHR lacked a physician's order prior to that time. During an observation on 3/29/22, at 11:30 a.m., R24 was observed in bed with a CPAP mask on. During an observation on 3/29/22, at 11:59 a.m.,	F 695	F695- D Respiratory/Tracheostomy Care and Suctioning Facility failed to obtain a physician□s order for Continuous Positive Airway Pressure (CPAP) therapy for one resident reviewed for respiratory care. 1. F695 2. Order for CPAP was obtained 3/31/22 for R24. All other residents with obstructive sleep apnea were reviewed for CPAP orders. 3. All residents with sleep apnea who use CPAPs are at risk of being affected by this deficient practice. 4. Education provided to nursing staff related to the importance of having a CPAP order in place for a resident who requires a CPAP. 5. Audits initiated 4/21/22 to be completed and audited by the DON or designee once weekly for four weeks then every other week for one month. Audits will be reviewed at QAPI for review. 6. DON/designee will be responsible for compliance. 7. This deficiency will be corrected 5/9/22.	

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F 695	Continued From page 16 R24 was observed sitting on the edge of his bed and the CPAP machine was located next to him on his overbed table. During an observation on 3/31/22, at 8:58 a.m., R24 was observed in bed with his CPAP mask on. During an interview on 3/31/22, at 8:10 a.m., the assistant director of nurses (ADON) stated she was not certain why there was no order for R24's CPAP and believed the order may have "dropped off" when R24 returned from the hospital on 3/14/22. During an observation on 3/31/22, at 11:15 a.m. the ADON revealed R24's CPAP machine was observed to be set at the "home setting" of 9.0-12.0 pressure. During a follow-up interview on 3/31/22, at 10:39 a.m. the ADON was asked about the CPAP order which had since been obtained on 3/31/22, and included the "home setting." The ADON stated she was not sure what "home setting" meant. Review of the facility's policy titled CPAP/BiPAP Use dated 08/01/15, revealed residents using CPAP/BiPAP would require a physician's order to include approved order setting, duration of use and use of humidifier, if necessary and a supporting diagnosis.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		5/2/22

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F 880	Continued From page 17 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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	245581	A. BUILDING _____ B. WING _____	C 03/31/2022

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 880	Continued From page 18 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal protective equipment (PPE) was used when providing direct care for 3 of 5 residents (R17, R245 and R249) who were in droplet precautions. In addition, the facility failed to ensure resident catheter collection bag was stored in a manner to prevent infection for 1 of 2 residents (R30) reviewed for urinary catheters. Findings include: Transmission Based Precautions R17 R17's quarterly Minimum Data Set (MDS) dated	F 880	F880- D Infection Control and Prevention Facility failed to ensure PPE was used when providing direct care of three of five residents who were in droplet precautions. In addition, facility failed to ensure resident catheter collection bag was stored in a manner to prevent infection for one of two reviewed for urinary catheters. 1. F880 (Directed Plan of Correction) 2. R30□s catheter collection bag was covered as appropriate with a catheter bag cover on 3/30/22. The DON verbally corrected the cook□s deficient behavior in the presence of the surveyor on 3/30/22, reminding the cook of the appropriate PPE that is to be worn in rooms who	

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F 880	Continued From page 19 2/10/22, identified R17 had diagnoses which included dementia, depression, and end stage renal disease. The MDS identified R17 had severe cognitive impairment, required extensive assistance with personal hygiene and was totally dependent for activities of daily living (ADL's) with dressing and bathing. Review of R17's nursing progress notes dated 3/27/22, identified R17 had wheezing and required as needed inhalers for shortness of breath. A later note revealed R17 was placed on precautions for upper respiratory symptoms. During an observation on 3/28/22, at 4:48 p.m. R17 was noted to be laying on her back in bed, eyes were closed, covered with a blanket from her feet to upper chest. R17's door had a laminated eight (8) by 11 inch laminated sign which identified R17 was on contact and droplet precautions, and revealed a mask, gown, eye wear and gloves were required to enter the room. A further laminated sign, identified an N95 mask was required for entry. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/29/22, at 10:21 a.m. R17 was seated in a tilt in space wheelchair in her room, had a wet cough and congestion in her throat she was unable to clear. R17's door to her room had contact and droplet precautions signs placed which identified an N95 was required to be worn. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two	F 880	require droplet precautions, including R249. NA-E donned an appropriate N95 mask when he located them in the drawer outside of R17□s door on 3/30/22. NA-D was verbally educated on 3/30/22 of the importance of donning all appropriate PPE prior to entering an isolation room, including R245□s, even if just making a bed. 3. Residents and their representatives received education on the facility□s infection prevention control program as it related to them and to the degree possible/consistent with resident□s capacity. All residents who require contact and/or droplet precautions and all residents with catheters could be affected by this deficient practice. 4. The QAPI team and/or designee, conducted a root cause analysis to identify the problem that resulted in this deficiency. The Infection Preventionist and DON reviewed policies and procedures for donning/doffing PPE, during Covid-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care, policies and procedures for source control masks and use of gowns, as well as policies regarding standard and transmission-based precautions. All residents with catheters were reviewed to ensure physician orders and care plans gave instruction on placement and storage of the catheter collection bags. 5. Education provided to direct care staff and all staff who enter resident□s rooms related to standard infection control practices, including but not limited to,	

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F 880	Continued From page 20 types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/29/22, at 2:38 p.m. R17 was noted to be laying on her back in bed, covered with a blue blanket up to her chin. R17's doorway continued to have signs, identifying contact and droplet precautions which identified an N95 was required to be worn. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/30/22, at 8:14 a.m. R17 was noted to be laying in bed on her back, eyes were closed and was covered with a blanket from her feet to her chin. At that time, nursing assistant (NA)-E and NA-C, entered R17's room and proceeded to assist R17 with morning cares. NA-E had on eye protection, a medical grade mask, gloves and a disposable gown, NA-C wore eye protection, an N95 mask, gloves and a disposable gown and both proceeded to assist R17 with morning cares. -at 8:38 a.m. licensed practical nurse (LPN)-C entered R17's room, she wore eye protection, an N95 mask, gloves and a disposable gown and proceeded to assist R17 to transfer from her bed to a tilt in space chair with a full mechanical lift with NA-E. NA-E remained wearing a medical grade mask. - at 8:42 a.m. NA-E left R17's room, removed his gloves, gown, medical grade mask, completed hand hygiene and donned a new medical grade mask.	F 880	transmission-based precautions, appropriate PPE use, and donning and doffing of PPE. Training included competency testing of staff which was documented via attestation statement of completion. Furthermore, education was provided to direct care staff related to overall catheter care, placement, and storage. 6. The DON, Infection Preventionist and/or designee will conduct real-time audits of donning/doffing PPE with transmission-based precautions on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Real time audits will also include aerosolized generating procedures and proper use of gowns to ensure PPE is in use. Audits will continue until 100% compliance is met on source control masking for staff, visitors, and residents. Audits will be reviewed at QAPI for review. Catheter care audits initiated on 5/2/22 to be completed and audited by the DON or designee three times weekly for four weeks, then weekly for one month. Audits will be reviewed at QAPI for review. 7. DON/Infection Preventionist/Designee responsible for compliance. 8. This deficiency will be corrected 5/2/22.	

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F 880	Continued From page 21 During an interview on 3/30/22, at 8:43 a.m. NA-E stated R17 was on contact and droplet precautions and indicated staff were to wear the following when entering her room; gown, gloves, eye protection and an N95 mask. NA-E stated he was not able to wear an N95 into R17's room, as there were none available. NA-E then moved to a four drawer plastic container outside of R17's room, pulled the second drawer open, revealed several dozen N95 masks. NA-E proceeded to pull the third drawer open, which revealed another several dozen N95 masks. NA-E indicated he had not checked the drawers before entering R17's room. During an interview on 3/30/22, at 12:37 a.m. NA-C stated R17 was currently on contact and droplet precautions due to a cough and other respiratory symptoms. NA-C indicated an N95 was required to be worn in R17's room, and changed to another mask, (medical grade if vaccinated and another N95 if unvaccinated) after leaving R17's room. During an interview on 3/30/22, at 1:05 p.m. LPN-B confirmed R17 was on contact and droplet precautions and staff were required to wear an N95 mask when in her room. LPN-B stated she did not notice what type of mask NA-E had on when R17's morning cares were provided. She indicated had she noticed NA-E had a medical grade mask on, she would have provided education and had him to change to an N95. During an interview on 3/31/22, at 8:37 a.m. the facility infection preventionist (IP) confirmed R17 had been placed on contact and droplet precautions due to respiratory symptoms and had	F 880		

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F 880	Continued From page 22 tested negative for COVID-19. The IP stated staff were required to wear an N95 in contact/droplet precaution rooms, along with gowns, gloves, and eye protection. R249 Review of R249's face sheet in the electronic health record (EHR), revealed R249 was admitted to the facility on 3/24/22. Review of R249's immunizations record in the EHR identified R249 was not up to date with all the recommended COVID-19 vaccine doses. Therefore, R249 was placed on Contact and Droplet Precautions upon admission. During an observation 3/29/22, at 11:12 a.m. of R249's room revealed signs on the door which read "Contact and Droplet Precautions." The signs indicated staff entering the room were to don (put on) eye protection, N95 mask, isolation gown, and gloves. The supplies for the staff to don prior to entering the room were located in a set of drawers outside the room. During an observation on 3/29/22, at 10:56 a.m., nursing assistant (NA)-D entered R249's room, with linens to make the bed in the room without wearing an isolation gown. During an interview on 3/29/22, at 10:56 a.m., NA-D verbalized she should have been wearing a gown when entering the room and confirmed she did not wear a gown when she was in R249's room. R245	F 880		

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F 880	Continued From page 23	F 880		

Review of R245's face sheet in the EHR, revealed R245 was admitted to the facility on 3/25/22.

Review of R245's immunizations record in the EHR revealed R245 was not up to date with all the recommended COVID-19 vaccine doses. Therefore, R245 was placed on Contact and Droplet Precautions upon admission.

During an observation on 3/28/22, at 4:45 p.m. R245's room had signs on the door which read "Contact and Droplet Precautions." The signs indicated staff entering the room were to don eye protection, N95 mask, isolation gown, and gloves. The supplies for the staff to don prior to entering the room were located in a set of drawers outside the room.

During an observation on 3/29/22, at 12:11 p.m., the Cook (C)-A was observed in R245's room serving R245 a lunch tray while not wearing a gown.

During an interview on 3/29/22, at 12:12 p.m., the director of nursing (DON) indicated she had observed C-A in R245's room serving the lunch tray without wearing an isolation gown. The DON confirmed C-A should have donned a gown prior to entering R245's room due to the resident being on Contact and Droplet isolation.

Review of the facility policy titled Admission, Transfers, and return from Outings for Residents during [the] COVID-19 Pandemic revised 2/12/22, identified upon admission and/or readmission residents who were not up to date with COVID-19 vaccinations would be placed on droplet and contact precautions for a period of 10 days.

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F 880	Continued From page 24 Review of the facility policy titled Isolation Precautions revised 6/23/20, identified transmission-based precautions would be used when transmission could not be reasonably prevented by standard precautions alone and the facility was expected to post clear signage on the door or wall outside of the resident room indicating the type of precautions and required personal protective equipment (PPE). Catheter Care R30's quarterly Minimum Data Set (MDS) dated 3/3/22, identified R30 had diagnoses which included dementia, bilateral above the knee amputations and obstructive uropathy. The MDS identified R30 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene and was totally dependent for bathing. The MDS identified R30 had an indwelling urinary catheter. R30's current physician orders revealed an order for a supra pubic catheter (surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow), catheter care every shift, cleanse tubing, catheter is anchored via Velcro or tape. R30's physician orders lacked direction on placement of the catheter collection bag. R30's current care plan revised 3/24/22, revealed R30 required a supra pubic catheter due to significant urinary retention and obstructive uropathy. The care plan lacked instructions for placement of R17's catheter collection bag.	F 880		

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F 880	Continued From page 25 During an observation on 3/28/22, at 5:18 p.m. R30 was noted to be laying on his back in low bed, his eyes were closed and he was covered with a blanket from his lower extremities to his mid chest. R30's catheter tubing was observed from underneath the blanket on the left side of his bed, and lead to a collection bag which laid directly on a fall mat on the floor. - at 6:49 p.m. R30 was observed to remain laying in bed on his back in a low bed (bed that is able to be lowered to ground level), his eyes were closed and he was covered with a blanket. R30's catheter collection bag remained laying directly on a fall mat on the floor. During an observation on 3/29/22, at 10:51 a.m. R30 was noted to be laying in bed on his back, in a low bed. R30's eyes were closed, he was covered with a blanket up to the top of his chest. R30's catheter collection bag was observed laying on the left side of his bed, directly on a fall mat on the floor. During an observation on 3/30/22, at 7:34 a.m. R30 was noted to be laying in bed on his back, in a low bed. R30's catheter collection bag was observed hanging off the left side of his bed, laying directly on a fall mat on the floor. - at 9:33 a.m. R30 was observed laying on his back in a low bed, his eyes were closed and he was covered with a blanket from his legs to his chest. R30's catheter collection bag, half full of yellow urine, was observed laying directly on a fall mat on the floor. - at 2:22 p.m. R30 was observed laying on his	F 880		

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F 880	Continued From page 26	F 880		

back in a low bed, his eyes were opened. R30's catheter collection bag was observed laying on the floor on the left side of his bed, no urine was observed in the bag, which lied directly on a fall mat on the floor.

During an interview on 3/30/22, at 2:23 p.m. NA-E stated R30 was totally dependent for all ADL's, which included dressing, personal hygiene and bathing. NA-E indicated R30 had a catheter, received catheter cares twice daily and indicated the collection bag was to be placed below R30's bladder, on the ground or underneath R30's wheelchair. NA-E was unaware of any cover used for R30's catheter collection bag.

During an interview on 3/30/22, at 2:40 p.m. licensed practical nurse (LPN)-A confirmed R30's catheter collection bag was laying directly on a fall mat on R30's floor. LPN- walked over to a chair in R30's room, and took hold of a black plastic bag. LPN-A opened the bag which revealed a black plastic catheter bag holder, she then took R30's catheter collection bag and placed it into the black bag and placed the catheter back on the left side of R30's bed. LPN-A stated she had brought the catheter bag cover into R30's room a few days ago. She indicated R30's low bed prevented the catheter collection bag from being completely off the floor, however the cover was needed to assist with infection control and for dignity.

During an interview on 3/31/22, at 8:46 a.m. the infection preventionist (IP) stated she would expect resident catheter collection bags to be placed in a cover and kept off the floor if at all possible. IP stated R30 had a low bed, which prevented the catheter from being off the floor,

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F 880	Continued From page 27 however she expected the collection bag to be covered to minimize possible infection control concerns. A facility policy titled, Foley Catheter Management, revised 11/4/20, identified catheter bags would be covered at all times.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 18, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 06P711

Dear Administrator:

The above facility was surveyed on March 28, 2022 through March 31, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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	00679	A. BUILDING: _____ B. WING _____	C 03/31/2022

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FAIR OAKS NURSING & REHAB LLC	201 SHADY LANE DRIVE WADENA, MN 56482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/28/22, to 3/31/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. 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 surveyors 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 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance with routine grooming which included facial hair removal for 2 of 2 residents (R17 and R30) who required assistance with grooming and personal hygiene. Findings include: R17's quarterly Minimum Data Set (MDS) dated 2/10/22, identified R17 had diagnoses which included dementia, depression, and end stage renal disease. The MDS identified R17 had severe cognitive impairment, required extensive assistance with personal hygiene and was totally dependent for activities of daily living (ADL's) of dressing and bathing. The MDS revealed R17 had no rejection of cares during the seven day look back period. R17's care plan revised 1/26/22, identified R17	2 920	No POC required.	5/9/22

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2 920	Continued From page 3 had an ADL deficit, required assistance with dressing, bathing and personal hygiene. R17's care plan directed facility staff to check nail length and to attempt to trim and clean on bath day, as necessary and preferred to have long nails. R17's care plan lacked direction and preferences for facial hair removal. On 3/28/22, at 4:48 p.m. R17 was observed laying on her back in bed, eyes were closed, covered with a blanket from her feet to upper chest. R17 had several dozen, approximately five (5) to seven (7) millimeters (mm) long, white, wispy chin hairs and several dozen, two (2) to three (3) mm long, thick, course black hair along her chin, upper lip and corners of her mouth. On 3/29/22, at 9:45 a.m. R17 was observed seated in a tilt in space wheelchair (specialized wheelchair for positioning) in her room with her eyes closed. R17 faced the doorway, she had an over the bed, rolling table placed in front of her. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's hands rested on her lap, all ten of her fingernails were approximately 2-3 mm of length, were jagged, had chipped mauve colored nail polish and were observed to have a thick brownish substance underneath the length of all ten of her fingernails. - at 2:38 p.m. during an observation, R17 was laying on her back in bed, covered with a blue blanket up to her chin. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's hands rested on	2 920		

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2 920	Continued From page 4 her chest, all ten of her fingernails were approximately 2-3 mm of length, were jagged, had chipped mauve colored nail polish and were observed to have a thick brownish substance underneath the length of all ten of her fingernails. On 3/30/22, at 8:14 a.m. during an observation, R17 was laying in bed on her back, eyes were closed and was covered with a blanket from her feet to her chin. At that time, nursing assistant (NA)-E and NA-C, entered R17's room and proceeded to assist R17 with morning cares. R17 was assisted from her bed to a tilt in space wheelchair, NA-E proceeded to brush R17's hair. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. - at 9:46 a.m. during an observation, R17 remained seated in a tilt in space chair in her room with an over the bed table in front of her. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. - at 11:51 a.m. during an observation, R17 was seated in a tilt in space chair in her room, positioned to face the doorway. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's	2 920		

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2 920	Continued From page 5 fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. On 3/30/22, at 8:43 a.m. during an interview, NA-E indicated R17 was totally dependent for all ADL's, which included dressing, personal hygiene and bathing. NA-E indicated he did not feel R17 was able to verbalize her needs or wishes and staff were to anticipate her needs. NA-E stated he did not offer to remove R17's facial hair and did not attempt to provide nail care. NA-E indicated he was not aware of R17's preferences regarding facial hair removal and was not sure who was responsible for R17's nail care. On 3/30/22, at 12:37 p.m. during an interview, NA-C stated R17 was totally dependent for all of her ADL's of dressing, bathing, personal hygiene and all mobility. NA-C confirmed R17 was not offered to have her facial hair removed during morning cares and had not been offered since. NA-C indicated R17's nail were cleaned and filed on her bath day and as needed by other staff. NA-C stated she was not sure what the brown substance was underneath R17's nails and indicated she was not sure how long the substance had been underneath R17's fingernails. On 3/30/22, at 12:53 p.m. during an interview, licensed practical nurse (LPN)-B confirmed R17 had dozens of 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. LPN-B also confirmed R17's fingernails were jagged, and had a thick brownish substance underneath the length of all ten fingernails. LPN-B stated she felt it would be important to R17 to be shaved daily and to have	2 920		

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2 920	Continued From page 6 her nails, neatly painted and filed. LPN-B indicated R17 used to take pride in her appearance prior to her dementia diagnosis. On 3/31/22, at 8:37 a.m. during an interview the assistant director of nursing (ADON) stated she felt R17 did not like anyone to touch her fingernails, preferred them long and felt it was difficult to keep her nails well manicured. The ADON stated she felt R17 likely had refused to have her facial hair removed, indicated the facility activity staff had been assisting with resident cares such as nail care, facial hair removal and other grooming and felt they were not aware of how to document resident refusals. The ADON stated she would expect R17 to be offered to shave daily and have her nail care provided as she would allow. On 3/31/22, at 9:23 a.m. during a telephone interview, R17's family member (FM)-A stated prior to R17's dementia diagnosis, she had taken pride in her overall appearance and had well manicured fingernails. FM-A indicated he had spoken to facility staff in the past year about concerns with R17's facial hair, nails and overall appearance. FM-A stated he expected R17 be assisted to remove her facial hair and be well groomed on a daily basis. On 3/31/22, at 9:27 a.m. during an interview, activity director (AD)-A stated R17 had been offered nail care and shaving on Monday, 3/28/22, and had refused. AD-A indicated she was unaware if R17 had been offered assistance with shaving or nail care on any days following her refusal. AD-A stated R17 had been assisted with shaving following interview with nursing staff on 3/30/22.	2 920		

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2 920	Continued From page 7 R30 R30's quarterly Minimum Data Set (MDS) dated 3/3/22, identified R30 had diagnoses which included dementia, anxiety and bilateral above the knee amputations. The MDS identified R30 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene and was totally dependent for bathing. The MDS identified R30 had no rejection of cares during the assessment period. R30's care plan revised 3/24/22, revealed R30 had an ADL self care deficit, required assistance with dressing, bathing, and personal hygiene. The care plan did not identify R30's facial hair or shaving preferences. On 3/28/22, at 5:12 p.m. during a telephone interview, R30's family member (FM)-B stated R30 liked to have a neat, clean appearance and would shave his facial hair daily. FM-B indicated R30 had a mustache oftentimes in the past, but did not have a beard, and liked to be clean shaven. FM-B indicated, a few months prior, R30's wife had voiced concerns about R30's appearance. She indicated R30's hair was unkept, he was unshaven and overall messy in appearance. FM-B indicated she had spoken to nursing and had not seen or heard any further concerns regarding R30's appearance since then. On 3/28/22, at 5:18 p.m. R30 was observed laying in bed on his back, his eyes closed and was covered with a blanket from his lower extremities up to his mid chest. R30's beard line was covered with thick, course, white/gray stubble approximately two (2) to three (3) millimeter (mm) long, along his cheeks, chin,	2 920		

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2 920	Continued From page 8 neck and upper lip. On 3/29/22, at 10:51 a.m. R30 was observed laying in bed on his back in a low bed, eyes closed and was covered with a blanket up to the top of his chest. R30 continued to have thick, course, white/gray facial stubble, approximately 2-3 mm long, along his cheeks, chin, neck and around his mouth. -at 3:46 p.m. R30 was observed seated in a tilt in space chair in his room and faced the window. R30 continued to have thick, course, white/gray facial stubble, approximately 2-3 mm long, along his cheeks, chin, neck and around his mouth. On 3/30/22, at 7:34 a.m. R30 was observed laying in his bed, on his back, eyes were closed and was covered with a blanket up to the top of his chest. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to four (4) mm long, along his cheeks, chin, neck and around his mouth. -at 11:44 a.m. R30 was observed seated in a tilt in space chair in the common area of the unit. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to 4 mm long, along his cheeks, chin, neck and around his mouth. - at 2:22 p.m. R30 was observed laying in bed on his back, his eyes were opened, he was covered with a blanket up to his chin. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to four (4) mm long, along his cheeks, chin, neck and around his mouth. On 3/30/22, at 2:23 p.m. nursing assistant (NA)-E stated R30 was totally dependent for all ADL's,	2 920		

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2 920	Continued From page 9 which included dressing, personal hygiene and bathing. NA-E indicated R30 was shaved twice weekly and he had not shaved R30 in the past couple of days. On 3/30/22, at 2:40 p.m. licensed practical nurse (LPN)-A confirmed R30's facial hair, indicated it appeared R30 had not been shaved for a few days. LPN-A indicated R30 preferred to be clean shaven and should have been shaved daily. On 3/31/22, at 8:46 p.m. the facility administrator stated she felt R30 had refused shaving and routinely refused cares. The administrator indicated R30 historically was verbally aggressive with staff and could be very difficult to work with. She indicated she was not aware if staff were documenting R30's refusals, though would expect staff to document all refusals of care. On 3/31/22, at 9:30 a.m. the activity director (AD)-A stated R30 was approached on Monday, 3/28/22, and was offered shaving at that time. The AD-A indicated she was not aware if R30 had been offered to shave any other days during the week, but felt staff would assist if he allowed. A facility policy titled, Activities of Daily Living (ADL's) revised 3/15/21, identified based on assessment and resident needs and choices, the facility must provide the necessary care and services. The policy revealed the facility would provide the following ADL's, which included hygiene of bathing, dressing, grooming and oral cares. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to activities of daily living. The director of nursing	2 920		

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2 920	Continued From page 10 or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing assistance with activities of daily living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		5/9/22

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21390	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal protective equipment (PPE) was used when providing direct care for 3 of 5 residents (R17, R245 and R249) who were in droplet precautions. In addition, the facility failed to ensure resident catheter collection bag was stored in a manner to prevent infection for 1 of 2 residents (R30) reviewed for urinary catheters. Findings include: Transmission Based Precautions R17 R17's quarterly Minimum Data Set (MDS) dated 2/10/22, identified R17 had diagnoses which included dementia, depression, and end stage renal disease. The MDS identified R17 had severe cognitive impairment, required extensive assistance with personal hygiene and was totally dependent for activities of daily living (ADL's) with dressing and bathing. Review of R17's nursing progress notes dated 3/27/22, identified R17 had wheezing and required as needed inhalers for shortness of breath. A later note revealed R17 was placed on precautions for upper respiratory symptoms. During an observation on 3/28/22, at 4:48 p.m. R17 was noted to be laying on her back in bed, eyes were closed, covered with a blanket from her feet to upper chest. R17's door had a laminated eight (8) by 11 inch laminated sign which identified R17 was on contact and droplet	21390	No POC required.	

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21390	Continued From page 12 precautions, and revealed a mask, gown, eye wear and gloves were required to enter the room. A further laminated sign, identified an N95 mask was required for entry. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/29/22, at 10:21 a.m. R17 was seated in a tilt in space wheelchair in her room, had a wet cough and congestion in her throat she was unable to clear. R17's door to her room had contact and droplet precautions signs placed which identified an N95 was required to be worn. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/29/22, at 2:38 p.m. R17 was noted to be laying on her back in bed, covered with a blue blanket up to her chin. R17's doorway continued to have signs, identifying contact and droplet precautions which identified an N95 was required to be worn. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/30/22, at 8:14 a.m. R17 was noted to be laying in bed on her back, eyes were closed and was covered with a blanket from her feet to her chin. At that time, nursing assistant (NA)-E and NA-C, entered R17's room and proceeded to assist R17 with morning cares.	21390		

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	00679	A. BUILDING: _____ B. WING _____	C 03/31/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 13 NA-E had on eye protection, a medical grade mask, gloves and a disposable gown, NA-C wore eye protection, an N95 mask, gloves and a disposable gown and both proceeded to assist R17 with morning cares. -at 8:38 a.m. licensed practical nurse (LPN)-C entered R17's room, she wore eye protection, an N95 mask, gloves and a disposable gown and proceeded to assist R17 to transfer from her bed to a tilt in space chair with a full mechanical lift with NA-E. NA-E remained wearing a medical grade mask. - at 8:42 a.m. NA-E left R17's room, removed his gloves, gown, medical grade mask, completed hand hygiene and donned a new medical grade mask. During an interview on 3/30/22, at 8:43 a.m. NA-E stated R17 was on contact and droplet precautions and indicated staff were to wear the following when entering her room; gown, gloves, eye protection and an N95 mask. NA-E stated he was not able to wear an N95 into R17's room, as there were none available. NA-E then moved to a four drawer plastic container outside of R17's room, pulled the second drawer open, revealed several dozen N95 masks. NA-E proceeded to pull the third drawer open, which revealed another several dozen N95 masks. NA-E indicated he had not checked the drawers before entering R17's room. During an interview on 3/30/22, at 12:37 a.m. NA-C stated R17 was currently on contact and droplet precautions due to a cough and other respiratory symptoms. NA-C indicated an N95 was required to be worn in R17's room, and changed to another mask, (medical grade if	21390		

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21390	Continued From page 14 vaccinated and another N95 if unvaccinated) after leaving R17's room. During an interview on 3/30/22, at 1:05 p.m. LPN-B confirmed R17 was on contact and droplet precautions and staff were required to wear an N95 mask when in her room. LPN-B stated she did not notice what type of mask NA-E had on when R17's morning cares were provided. She indicated had she noticed NA-E had a medical grade mask on, she would have provided education and had him to change to an N95. During an interview on 3/31/22, at 8:37 a.m. the facility infection preventionist (IP) confirmed R17 had been placed on contact and droplet precautions due to respiratory symptoms and had tested negative for COVID-19. The IP stated staff were required to wear an N95 in contact/droplet precaution rooms, along with gowns, gloves, and eye protection. R249 Review of R249's face sheet in the electronic health record (EHR), revealed R249 was admitted to the facility on 3/24/22. Review of R249's immunizations record in the EHR identified R249 was not up to date with all the recommended COVID-19 vaccine doses. Therefore, R249 was placed on Contact and Droplet Precautions upon admission. During an observation 3/29/22, at 11:12 a.m. of R249's room revealed signs on the door which read "Contact and Droplet Precautions." The signs indicated staff entering the room were to don (put on) eye protection, N95 mask, isolation gown, and gloves. The supplies for the staff to	21390		

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21390	Continued From page 15 don prior to entering the room were located in a set of drawers outside the room. During an observation on 3/29/22, at 10:56 a.m., nursing assistant (NA)-D entered R249's room, with linens to make the bed in the room without wearing an isolation gown. During an interview on 3/29/22, at 10:56 a.m., NA-D verbalized she should have been wearing a gown when entering the room and confirmed she did not wear a gown when she was in R249's room. R245 Review of R245's face sheet in the EHR, revealed R245 was admitted to the facility on 3/25/22. Review of R245's immunizations record in the EHR revealed R245 was not up to date with all the recommended COVID-19 vaccine doses. Therefore, R245 was placed on Contact and Droplet Precautions upon admission. During an observation on 3/28/22, at 4:45 p.m. R245's room had signs on the door which read "Contact and Droplet Precautions." The signs indicated staff entering the room were to don eye protection, N95 mask, isolation gown, and gloves. The supplies for the staff to don prior to entering the room were located in a set of drawers outside the room. During an observation on 3/29/22, at 12:11 p.m., the Cook (C)-A was observed in R245's room serving R245 a lunch tray while not wearing a gown.	21390		

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21390	Continued From page 16 During an interview on 3/29/22, at 12:12 p.m., the director of nursing (DON) indicated she had observed C-A in R245's room serving the lunch tray without wearing an isolation gown. The DON confirmed C-A should have donned a gown prior to entering R245's room due to the resident being on Contact and Droplet isolation. Review of the facility policy titled Admission, Transfers, and return from Outings for Residents during [the] COVID-19 Pandemic revised 2/12/22, identified upon admission and/or readmission residents who were not up to date with COVID-19 vaccinations would be placed on droplet and contact precautions for a period of 10 days. Review of the facility policy titled Isolation Precautions revised 6/23/20, identified transmission-based precautions would be used when transmission could not be reasonably prevented by standard precautions alone and the facility was expected to post clear signage on the door or wall outside of the resident room indicating the type of precautions and required personal protective equipment (PPE). Catheter Care R30's quarterly Minimum Data Set (MDS) dated 3/3/22, identified R30 had diagnoses which included dementia, bilateral above the knee amputations and obstructive uropathy. The MDS identified R30 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene and was totally dependent for bathing. The MDS identified R30 had an indwelling urinary catheter. R30's current physician orders revealed an order	21390		

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21390	Continued From page 17	21390		

for a supra pubic catheter (surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow), catheter care every shift, cleanse tubing, catheter is anchored via Velcro or tape. R30's physician orders lacked direction on placement of the catheter collection bag.

R30's current care plan revised 3/24/22, revealed R30 required a supra pubic catheter due to significant urinary retention and obstructive uropathy. The care plan lacked instructions for placement of R17's catheter collection bag.

During an observation on 3/28/22, at 5:18 p.m. R30 was noted to be laying on his back in low bed, his eyes were closed and he was covered with a blanket from his lower extremities to his mid chest. R30's catheter tubing was observed from underneath the blanket on the left side of his bed, and lead to a collection bag which laid directly on a fall mat on the floor.

- at 6:49 p.m. R30 was observed to remain laying in bed on his back in a low bed (bed that is able to be lowered to ground level), his eyes were closed and he was covered with a blanket. R30's catheter collection bag remained laying directly on a fall mat on the floor.

During an observation on 3/29/22, at 10:51 a.m. R30 was noted to be laying in bed on his back, in a low bed. R30's eyes were closed, he was covered with a blanket up to the top of his chest. R30's catheter collection bag was observed laying on the left side of his bed, directly on a fall mat on the floor.

During an observation on 3/30/22, at 7:34 a.m.

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21390	Continued From page 18 R30 was noted to be laying in bed on his back, in a low bed. R30's catheter collection bag was observed hanging off the left side of his bed, laying directly on a fall mat on the floor. - at 9:33 a.m. R30 was observed laying on his back in a low bed, his eyes were closed and he was covered with a blanket from his legs to his chest. R30's catheter collection bag, half full of yellow urine, was observed laying directly on a fall mat on the floor. - at 2:22 p.m. R30 was observed laying on his back in a low bed, his eyes were opened. R30's catheter collection bag was observed laying on the floor on the left side of his bed, no urine was observed in the bag, which lied directly on a fall mat on the floor. During an interview on 3/30/22, at 2:23 p.m. NA-E stated R30 was totally dependent for all ADL's, which included dressing, personal hygiene and bathing. NA-E indicated R30 had a catheter, received catheter cares twice daily and indicated the collection bag was to be placed below R30's bladder, on the ground or underneath R30's wheelchair. NA-E was unaware of any cover used for R30's catheter collection bag. During an interview on 3/30/22, at 2:40 p.m. licensed practical nurse (LPN)-A confirmed R30's catheter collection bag was laying directly on a fall mat on R30's floor. LPN- walked over to a chair in R30's room, and took hold of a black plastic bag. LPN-A opened the bag which revealed a black plastic catheter bag holder, she then took R30's catheter collection bag and placed it into the black bag and placed the catheter back on the left side of R30's bed. LPN-A stated she had brought the catheter bag cover into R30's room a	21390		

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21390	Continued From page 19 few days ago. She indicated R30's low bed prevented the catheter collection bag from being completely off the floor, however the cover was needed to assist with infection control and for dignity. During an interview on 3/31/22, at 8:46 a.m. the infection preventionist (IP) stated she would expect resident catheter collection bags to be placed in a cover and kept off the floor if at all possible. IP stated R30 had a low bed, which prevented the catheter from being off the floor, however she expected the collection bag to be covered to minimize possible infection control concerns. A facility policy titled, Foley Catheter Management, revised 11/4/20, identified catheter bags would be covered at all times. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review and revise policies and procedures related to ensuring transmission based precautions were followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are following guidance with personal protection equipment with identified transmission based precautions. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21390		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged.	21925		5/9/22

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21925	Continued From page 20 Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and review, the facility failed to notify the State Ombudsman's office of a facility transfer for one of two residents (R8) reviewed for transfers. Findings include: Review of the R8's form titled Face Sheet revealed R8 was admitted to the facility on 7/23/21, and readmitted on 1/31/22. Review of R8's progress notes from 1/30/22, to 1/31/22, revealed the following: -1/30/22, at 2:50 p.m. identified the ambulance	21925	No POC required.	

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21925	Continued From page 21	21925		

arrived at the facility and transported R8 to the emergency room due to R8's altered cognition. -1/31/22, at 6:50 p.m. R8 had been re-admitted to the hospital.

Review of the Ombudsman notifications for the month of January and February 2022, revealed no documentation the Ombudsman had been notified about R8's transfer to the hospital.

During an interview on 3/30/22, at 3:10 p.m., the Social Service Director (SSD) indicated the process for notification of the Ombudsman was to fax, at the beginning of the month, a list of residents transferred or discharged from the facility during the previous month. SSD confirmed review of the notifications for the month of January 2022, and February 2022, revealed the Ombudsman had been notified that R8 was transferred to the hospital.

During an interview on 3/30/22, at 3:15 p.m., the Minimum Data Set (MDS) Coordinator confirmed R8 was discharged from the facility on 1/30/22, at 2:50 p.m. and returned to the facility the next day, on 1/31/22, at 6:40 p.m.

During an interview on 3/30/22, at 3:20 p.m., the administrator stated the expectation was staff were to fax the Ombudsman the list of residents discharged on a monthly basis even if the resident had only been gone for one day. The administrator confirmed the notification of the discharge of R8 on 1/30/22, had not been communicated to the Ombudsman.

Review of the facility policy titled Admission, Readmission, Bed Hold, and Transfer/Discharge dated 1/04/19, revealed a copy of the [discharge] notice must be sent to a representative of the

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21925	Continued From page 22 Office of the State Long-Term Care Ombudsman. SUGGESTED METHOD OF CORRECTION: The Director of Social Services or designee could develop, review, and/or revise policies and procedures to ensure the ombudsman received notification of all hospitalizations. The Director of Social Services or designee could educate all appropriate staff on the policies and procedures. The Director of Social Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		

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	245581	A. BUILDING **01 - DINING ADDITION 01** B. WING _____	**03/29/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/29/2022. At the time of this survey, Fair Oaks Nursing & Rehab-Bldg 01 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Fair Oaks Nursing & Rehab was constructed at four different times. In 1995 the kitchen and dining building 02 was constructed to the west of the 1965 building and is a 2-story addition that was determined to be of Type IV(2HH) construction. It is separated by a 10-foot enclosed walkway and a 2-hour fire barrier. No sleeping rooms are in this building. The original building (01 Main Building) was constructed in 1965, was determined to be of Type II (222) construction, and has a wood roof system that meets NFPA 101 Sec 19.1.6.2. In 1972 a 3-story addition was constructed to the east of the original building that is a 3-story building; no basement was determined to be of Type II (222) construction, and it has a wood roof system that meets NFPA 101 Sec 19.1.6.2. In 1976, a 2-story addition was constructed to the south that was determined to be of Type II(222) construction. The facility was surveyed as two buildings. The facility is completely sprinkler protected with a dry pipe system and a wet pipe system. The facility has smoke detection in the corridor	K 000		

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

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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K 000	Continued From page 1 system, in all areas open to the corridor, in all common areas, and in all sleeping rooms that are on the facility's fire alarm system that has automatic fire department notification. The facility has a capacity of 75 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

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	245581	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**03/29/2022**

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FAIR OAKS NURSING & REHAB LLC	**201 SHADY LANE DRIVE WADENA, MN 56482**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/29/2022. At the time of this survey, Fair Oaks Nursing & Rehab-Bldg 02 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Fair Oaks Nursing & Rehab was constructed at four different times. In 1995 the kitchen and dining building 02 was constructed to the west of the 1965 building and is a 2-story addition that was determined to be of Type IV(2HH) construction. It is separated by a 10-foot enclosed walkway and a 2-hour fire barrier. No sleeping rooms are in this building. The original building (01 Main Building) was constructed in 1965, was determined to be of Type II (222) construction, and has a wood roof system that meets NFPA 101 Sec 19.1.6.2. In 1972 a 3-story addition was constructed to the east of the original building that is a 3-story building with no basement and was determined to be of Type II (222) construction and has a wood roof system that meets NFPA 101 Sec 19.1.6.2. In 1976, a 2-story addition was constructed to the south that was determined to be of Type II(222) construction. The facility was surveyed as two buildings. The facility is completely sprinkler protected with a dry pipe system and a wet pipe system. The facility has smoke detection in the corridor	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**03/29/2022**

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
K 000	Continued From page 1 system, in all areas open to the corridor, in all common areas, and in all sleeping rooms that are on the facility's fire alarm system that has automatic fire department notification. The facility has a capacity of 75 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 31, 2022

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

RE: CCN: 245581
Cycle Start Date: March 31, 2022

Dear Administrator:

On April 18, 2022, we notified you a remedy was imposed. On May 17, 2022 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 May 9, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 1, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 18, 2022, 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 July 1, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 9, 2022, 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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.
Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

May 31, 2022

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

Re: Reinspection Results
Event ID: 06P712

Dear Administrator:

On May 17, 2022 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 May 17, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
April 18, 2022

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

RE: CCN: 245581
Cycle Start Date: March 31, 2022

Dear Administrator:

On March 31, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 1, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2022.

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.

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

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 $11,292; 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 July 1, 2022, 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 July 1, 2022. 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 September 30, 2022 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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING _____ B. WING _____	C 03/31/2022

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
E 000	Initial Comments On 3/28/22, to 3/31/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/28/22, to 3/31/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5581067C (MN80810 and MN80869), H5581068C (MN79311). 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2022

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
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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		5/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 2 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 3 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and review, the facility failed to notify the State Ombudsman's office of a facility transfer for one of two residents (R8) reviewed for transfers. Findings include: Review of the R8's form titled Face Sheet revealed R8 was admitted to the facility on 7/23/21, and readmitted on 1/31/22. Review of R8's progress notes from 1/30/22, to 1/31/22, revealed the following: -1/30/22, at 2:50 p.m. identified the ambulance arrived at the facility and transported R8 to the emergency room due to R8's altered cognition. -1/31/22, at 6:50 p.m. R8 had been re-admitted to the hospital. Review of the Ombudsman notifications for the month of January and February 2022, revealed	F 623	F623- D Notice Requirements Before Transfer/Discharge The facility failed to notify the Ombudsman of a facility transfer for one resident who was hospitalized but returned to the facility. 1. F623 2. The ombudsman was notified of the resident□s transfer to the hospital (1/30/22) and readmission to FOL (1/31/22) on 3/30/22. All residents who have been transferred within the last three months were reviewed to ensure that notifications were sent to the Ombudsman timely. 3. All residents are at risk of being affected by this deficient practice. 4. Education provided to nursing staff and social services designee related to the procedure of transferring a resident	

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F 623	Continued From page 4 no documentation the Ombudsman had been notified about R8's transfer to the hospital. During an interview on 3/30/22, at 3:10 p.m., the Social Service Director (SSD) indicated the process for notification of the Ombudsman was to fax, at the beginning of the month, a list of residents transferred or discharged from the facility during the previous month. SSD confirmed review of the notifications for the month of January 2022, and February 2022, revealed the Ombudsman had been notified that R8 was transferred to the hospital. During an interview on 3/30/22, at 3:15 p.m., the Minimum Data Set (MDS) Coordinator confirmed R8 was discharged from the facility on 1/30/22, at 2:50 p.m. and returned to the facility the next day, on 1/31/22, at 6:40 p.m. During an interview on 3/30/22, at 3:20 p.m., the administrator stated the expectation was staff were to fax the Ombudsman the list of residents discharged on a monthly basis even if the resident had only been gone for one day. The administrator confirmed the notification of the discharge of R8 on 1/30/22, had not been communicated to the Ombudsman. Review of the facility policy titled Admission, Readmission, Bed Hold, and Transfer/Discharge dated 1/04/19, revealed a copy of the [discharge] notice must be sent to a representative of the Office of the State Long-Term Care Ombudsman.	F 623	out of point click care when he or she is sent to the hospital and sending the proper notification to the Ombudsman. 5. Audits initiated 4/21/22 to be completed and audited by the DON or designee two times weekly for four weeks, then every week for four weeks. Audits will be reviewed at QAPI for additional oversight and possible changes needed to ensure ongoing compliance. 6. DON/designee will be responsible for compliance. 7. This deficiency will be corrected 5/9/22.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		5/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 655	Continued From page 5 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655		

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	245581	A. BUILDING _____ B. WING _____	C 03/31/2022

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F 655	Continued From page 6 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a baseline care plan was completed within 48-hours of admission for one of four residents (R) 245 reviewed for baseline care plans. Findings include: Review of R245's face sheet revealed R245 was admitted to the facility on 3/25/22, with diagnoses which included sepsis (infection causing tissue injury), osteomyelitis (infection of the bone) of the right ankle, and a chronic ulcer to the lower left leg. Review of R245's baseline care plan identified the first two sections, General Information and Functional Status were completed on 3/25/22. The following six sections, Health Conditions, Dietary, Therapy, Social Services, Activities, and Baseline Care Plan (BCP) Summary and Signatures had not been completed. Additionally, the form lacked signatures from the resident and or family representative. During an interview on 3/31/22, at 9:50 a.m., the assistant director of nursing (ADON) stated staff were expected to complete the baseline care plans within 48-hours of admission. ADON confirmed R245's baseline care plan had not been completed. Review of the facility policy titled Care Plan-Baseline and Comprehensive, revised	F 655	F655- D Baseline Care Plan Facility failed to ensure a baseline care plan was completed within 48 hours of admission for one resident. 1. F655 2. Baseline care plan for R 245 completed 3/29/22. All residents who have admitted within the last week were reviewed to ensure that his or her baseline care plans have been completed timely. 3. All residents are at risk of being affected by this deficient practice. 4. Education provided to nursing staff, social services designee, therapy director, activity director and dietary manager related to timely completion of the baseline care plan upon admit. 5. Audits initiated 4/21/22 to be completed and audited by the DON or designee one time weekly for four weeks, then every other week for one month. Audits will be reviewed at QAPI for additional oversight and possible changes needed to ensure ongoing compliance. 6. DON/designee will be responsible for compliance. 7. This deficiency will be corrected 5/9/22.	

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F 655	Continued From page 7 2/12/22, revealed a baseline care plan would be developed within 48 hours of admission.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance with routine grooming which included facial hair removal for 2 of 2 residents (R17 and R30) who required assistance with grooming and personal hygiene. Findings include: R17's quarterly Minimum Data Set (MDS) dated 2/10/22, identified R17 had diagnoses which included dementia, depression, and end stage renal disease. The MDS identified R17 had severe cognitive impairment, required extensive assistance with personal hygiene and was totally dependent for activities of daily living (ADL's) of dressing and bathing. The MDS revealed R17 had no rejection of cares during the seven day look back period. R17's care plan revised 1/26/22, identified R17 had an ADL deficit, required assistance with dressing, bathing and personal hygiene. R17's care plan directed facility staff to check nail length and to attempt to trim and clean on bath day, as necessary and preferred to have long nails. R17's care plan lacked direction and preferences for	F 677	F677- D ADL Care Provided for Dependent Residents Facility failed to provide assistance with routine grooming which included facial hair removal for two residents who required assistance with grooming and personal hygiene. 1. F667 2. Facial hair was shaved, and fingernails were cleansed and trimmed for R17 and R30. All other residents assessed for shaving needs and shaved as required. All residents are at risk of being affected by this deficient practice. 3. All residents are at risk of being affected by this deficient practice. 4. Education provided to nursing staff and activity staff related to the importance of shaving per resident□s needs or desires. 5. Audits initiated 4/21/22 to be completed and audited by the DON or designee three times weekly for four weeks, then weekly for one month. Audits will be reviewed at QAPI for review. The audits determine whether the resident	5/9/22

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F 677	Continued From page 8 facial hair removal. On 3/28/22, at 4:48 p.m. R17 was observed laying on her back in bed, eyes were closed, covered with a blanket from her feet to upper chest. R17 had several dozen, approximately five (5) to seven (7) millimeters (mm) long, white, wispy chin hairs and several dozen, two (2) to three (3) mm long, thick, course black hair along her chin, upper lip and corners of her mouth. On 3/29/22, at 9:45 a.m. R17 was observed seated in a tilt in space wheelchair (specialized wheelchair for positioning) in her room with her eyes closed. R17 faced the doorway, she had an over the bed, rolling table placed in front of her. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's hands rested on her lap, all ten of her fingernails were approximately 2-3 mm of length, were jagged, had chipped mauve colored nail polish and were observed to have a thick brownish substance underneath the length of all ten of her fingernails. - at 2:38 p.m. during an observation, R17 was laying on her back in bed, covered with a blue blanket up to her chin. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's hands rested on her chest, all ten of her fingernails were approximately 2-3 mm of length, were jagged, had chipped mauve colored nail polish and were observed to have a thick brownish substance underneath the length of all ten of her fingernails.	F 677	was shaved, if they refused to shave, and if their care plan was updated to reflect his or her preference in shaving, if different than every day. 6. DON/designee will be responsible for compliance. 7. This deficiency will be corrected 5/9/22.	

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F 677	Continued From page 9 On 3/30/22, at 8:14 a.m. during an observation, R17 was laying in bed on her back, eyes were closed and was covered with a blanket from her feet to her chin. At that time, nursing assistant (NA)-E and NA-C, entered R17's room and proceeded to assist R17 with morning cares. R17 was assisted from her bed to a tilt in space wheelchair, NA-E proceeded to brush R17's hair. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. - at 9:46 a.m. during an observation, R17 remained seated in a tilt in space chair in her room with an over the bed table in front of her. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. - at 11:51 a.m. during an observation, R17 was seated in a tilt in space chair in her room, positioned to face the doorway. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails.	F 677		

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F 677	Continued From page 10 On 3/30/22, at 8:43 a.m. during an interview, NA-E indicated R17 was totally dependent for all ADL's, which included dressing, personal hygiene and bathing. NA-E indicated he did not feel R17 was able to verbalize her needs or wishes and staff were to anticipate her needs. NA-E stated he did not offer to remove R17's facial hair and did not attempt to provide nail care. NA-E indicated he was not aware of R17's preferences regarding facial hair removal and was not sure who was responsible for R17's nail care. On 3/30/22, at 12:37 p.m. during an interview, NA-C stated R17 was totally dependent for all of her ADL's of dressing, bathing, personal hygiene and all mobility. NA-C confirmed R17 was not offered to have her facial hair removed during morning cares and had not been offered since. NA-C indicated R17's nail were cleaned and filed on her bath day and as needed by other staff. NA-C stated she was not sure what the brown substance was underneath R17's nails and indicated she was not sure how long the substance had been underneath R17's fingernails. On 3/30/22, at 12:53 p.m. during an interview, licensed practical nurse (LPN)-B confirmed R17 had dozens of 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. LPN-B also confirmed R17's fingernails were jagged, and had a thick brownish substance underneath the length of all ten fingernails. LPN-B stated she felt it would be important to R17 to be shaved daily and to have her nails, neatly painted and filed. LPN-B indicated R17 used to take pride in her appearance prior to her dementia diagnosis.	F 677		

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F 677	Continued From page 11 On 3/31/22, at 8:37 a.m. during an interview the assistant director of nursing (ADON) stated she felt R17 did not like anyone to touch her fingernails, preferred them long and felt it was difficult to keep her nails well manicured. The ADON stated she felt R17 likely had refused to have her facial hair removed, indicated the facility activity staff had been assisting with resident cares such as nail care, facial hair removal and other grooming and felt they were not aware of how to document resident refusals. The ADON stated she would expect R17 to be offered to shave daily and have her nail care provided as she would allow. On 3/31/22, at 9:23 a.m. during a telephone interview, R17's family member (FM)-A stated prior to R17's dementia diagnosis, she had taken pride in her overall appearance and had well manicured fingernails. FM-A indicated he had spoken to facility staff in the past year about concerns with R17's facial hair, nails and overall appearance. FM-A stated he expected R17 be assisted to remove her facial hair and be well groomed on a daily basis. On 3/31/22, at 9:27 a.m. during an interview, activity director (AD)-A stated R17 had been offered nail care and shaving on Monday, 3/28/22, and had refused. AD-A indicated she was unaware if R17 had been offered assistance with shaving or nail care on any days following her refusal. AD-A stated R17 had been assisted with shaving following interview with nursing staff on 3/30/22. R30	F 677		

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F 677	Continued From page 12 R30's quarterly Minimum Data Set (MDS) dated 3/3/22, identified R30 had diagnoses which included dementia, anxiety and bilateral above the knee amputations. The MDS identified R30 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene and was totally dependent for bathing. The MDS identified R30 had no rejection of cares during the assessment period. R30's care plan revised 3/24/22, revealed R30 had an ADL self care deficit, required assistance with dressing, bathing, and personal hygiene. The care plan did not identify R30's facial hair or shaving preferences. On 3/28/22, at 5:12 p.m. during a telephone interview, R30's family member (FM)-B stated R30 liked to have a neat, clean appearance and would shave his facial hair daily. FM-B indicated R30 had a mustache oftentimes in the past, but did not have a beard, and liked to be clean shaven. FM-B indicated, a few months prior, R30's wife had voiced concerns about R30's appearance. She indicated R30's hair was unkept, he was unshaven and overall messy in appearance. FM-B indicated she had spoken to nursing and had not seen or heard any further concerns regarding R30's appearance since then. On 3/28/22, at 5:18 p.m. R30 was observed laying in bed on his back, his eyes closed and was covered with a blanket from his lower extremities up to his mid chest. R30's beard line was covered with thick, course, white/gray stubble approximately two (2) to three (3) millimeter (mm) long, along his cheeks, chin, neck and upper lip.	F 677		

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F 677	Continued From page 13 On 3/29/22, at 10:51 a.m. R30 was observed laying in bed on his back in a low bed, eyes closed and was covered with a blanket up to the top of his chest. R30 continued to have thick, course, white/gray facial stubble, approximately 2-3 mm long, along his cheeks, chin, neck and around his mouth. -at 3:46 p.m. R30 was observed seated in a tilt in space chair in his room and faced the window. R30 continued to have thick, course, white/gray facial stubble, approximately 2-3 mm long, along his cheeks, chin, neck and around his mouth. On 3/30/22, at 7:34 a.m. R30 was observed laying in his bed, on his back, eyes were closed and was covered with a blanket up to the top of his chest. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to four (4) mm long, along his cheeks, chin, neck and around his mouth. -at 11:44 a.m. R30 was observed seated in a tilt in space chair in the common area of the unit. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to 4 mm long, along his cheeks, chin, neck and around his mouth. - at 2:22 p.m. R30 was observed laying in bed on his back, his eyes were opened, he was covered with a blanket up to his chin. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to four (4) mm long, along his cheeks, chin, neck and around his mouth. On 3/30/22, at 2:23 p.m. nursing assistant (NA)-E stated R30 was totally dependent for all ADL's,	F 677		

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F 677	Continued From page 14 which included dressing, personal hygiene and bathing. NA-E indicated R30 was shaved twice weekly and he had not shaved R30 in the past couple of days. On 3/30/22, at 2:40 p.m. licensed practical nurse (LPN)-A confirmed R30's facial hair, indicated it appeared R30 had not been shaved for a few days. LPN-A indicated R30 preferred to be clean shaven and should have been shaved daily. On 3/31/22, at 8:46 p.m. the facility administrator stated she felt R30 had refused shaving and routinely refused cares. The administrator indicated R30 historically was verbally aggressive with staff and could be very difficult to work with. She indicated she was not aware if staff were documenting R30's refusals, though would expect staff to document all refusals of care. On 3/31/22, at 9:30 a.m. the activity director (AD)-A stated R30 was approached on Monday, 3/28/22, and was offered shaving at that time. The AD-A indicated she was not aware if R30 had been offered to shave any other days during the week, but felt staff would assist if he allowed. A facility policy titled, Activities of Daily Living (ADL's) revised 3/15/21, identified based on assessment and resident needs and choices, the facility must provide the necessary care and services. The policy revealed the facility would provide the following ADL's, which included hygiene of bathing, dressing, grooming and oral cares.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		5/9/22

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F 695	Continued From page 15 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to obtain a physician's order for Continuous Positive Airway Pressure (CPAP) (delivers oxygenated air into the airways through a mask and a tube) therapy for one of four residents (R24) reviewed for respiratory care. Findings include: Review of R24's significant change Minimum Data Set (MDS) dated of 2/28/22, identified R24 was admitted on 12/21/21, was cognitively intact, and used a CPAP. Review of R24's face sheet dated 3/14/22 identified R24 had a diagnosis of obstructive sleep apnea (sleep disorder where breathing repeatedly stops and starts). Review of R24's physician orders in the electronic health record (EHR) identified an order for a CPAP on while sleeping and at bedtime with at home settings was obtained on 3/31/22. The EHR lacked a physician's order prior to that time. During an observation on 3/29/22, at 11:30 a.m., R24 was observed in bed with a CPAP mask on. During an observation on 3/29/22, at 11:59 a.m.,	F 695	F695- D Respiratory/Tracheostomy Care and Suctioning Facility failed to obtain a physician□s order for Continuous Positive Airway Pressure (CPAP) therapy for one resident reviewed for respiratory care. 1. F695 2. Order for CPAP was obtained 3/31/22 for R24. All other residents with obstructive sleep apnea were reviewed for CPAP orders. 3. All residents with sleep apnea who use CPAPs are at risk of being affected by this deficient practice. 4. Education provided to nursing staff related to the importance of having a CPAP order in place for a resident who requires a CPAP. 5. Audits initiated 4/21/22 to be completed and audited by the DON or designee once weekly for four weeks then every other week for one month. Audits will be reviewed at QAPI for review. 6. DON/designee will be responsible for compliance. 7. This deficiency will be corrected 5/9/22.	

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F 695	Continued From page 16 R24 was observed sitting on the edge of his bed and the CPAP machine was located next to him on his overbed table. During an observation on 3/31/22, at 8:58 a.m., R24 was observed in bed with his CPAP mask on. During an interview on 3/31/22, at 8:10 a.m., the assistant director of nurses (ADON) stated she was not certain why there was no order for R24's CPAP and believed the order may have "dropped off" when R24 returned from the hospital on 3/14/22. During an observation on 3/31/22, at 11:15 a.m. the ADON revealed R24's CPAP machine was observed to be set at the "home setting" of 9.0-12.0 pressure. During a follow-up interview on 3/31/22, at 10:39 a.m. the ADON was asked about the CPAP order which had since been obtained on 3/31/22, and included the "home setting." The ADON stated she was not sure what "home setting" meant. Review of the facility's policy titled CPAP/BiPAP Use dated 08/01/15, revealed residents using CPAP/BiPAP would require a physician's order to include approved order setting, duration of use and use of humidifier, if necessary and a supporting diagnosis.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		5/2/22

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F 880	Continued From page 17 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 18 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal protective equipment (PPE) was used when providing direct care for 3 of 5 residents (R17, R245 and R249) who were in droplet precautions. In addition, the facility failed to ensure resident catheter collection bag was stored in a manner to prevent infection for 1 of 2 residents (R30) reviewed for urinary catheters. Findings include: Transmission Based Precautions R17 R17's quarterly Minimum Data Set (MDS) dated	F 880	F880- D Infection Control and Prevention Facility failed to ensure PPE was used when providing direct care of three of five residents who were in droplet precautions. In addition, facility failed to ensure resident catheter collection bag was stored in a manner to prevent infection for one of two reviewed for urinary catheters. 1. F880 (Directed Plan of Correction) 2. R30□s catheter collection bag was covered as appropriate with a catheter bag cover on 3/30/22. The DON verbally corrected the cook□s deficient behavior in the presence of the surveyor on 3/30/22, reminding the cook of the appropriate PPE that is to be worn in rooms who	

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F 880	Continued From page 19 2/10/22, identified R17 had diagnoses which included dementia, depression, and end stage renal disease. The MDS identified R17 had severe cognitive impairment, required extensive assistance with personal hygiene and was totally dependent for activities of daily living (ADL's) with dressing and bathing. Review of R17's nursing progress notes dated 3/27/22, identified R17 had wheezing and required as needed inhalers for shortness of breath. A later note revealed R17 was placed on precautions for upper respiratory symptoms. During an observation on 3/28/22, at 4:48 p.m. R17 was noted to be laying on her back in bed, eyes were closed, covered with a blanket from her feet to upper chest. R17's door had a laminated eight (8) by 11 inch laminated sign which identified R17 was on contact and droplet precautions, and revealed a mask, gown, eye wear and gloves were required to enter the room. A further laminated sign, identified an N95 mask was required for entry. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/29/22, at 10:21 a.m. R17 was seated in a tilt in space wheelchair in her room, had a wet cough and congestion in her throat she was unable to clear. R17's door to her room had contact and droplet precautions signs placed which identified an N95 was required to be worn. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two	F 880	require droplet precautions, including R249. NA-E donned an appropriate N95 mask when he located them in the drawer outside of R17□s door on 3/30/22. NA-D was verbally educated on 3/30/22 of the importance of donning all appropriate PPE prior to entering an isolation room, including R245□s, even if just making a bed. 3. Residents and their representatives received education on the facility□s infection prevention control program as it related to them and to the degree possible/consistent with resident□s capacity. All residents who require contact and/or droplet precautions and all residents with catheters could be affected by this deficient practice. 4. The QAPI team and/or designee, conducted a root cause analysis to identify the problem that resulted in this deficiency. The Infection Preventionist and DON reviewed policies and procedures for donning/doffing PPE, during Covid-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care, policies and procedures for source control masks and use of gowns, as well as policies regarding standard and transmission-based precautions. All residents with catheters were reviewed to ensure physician orders and care plans gave instruction on placement and storage of the catheter collection bags. 5. Education provided to direct care staff and all staff who enter resident□s rooms related to standard infection control practices, including but not limited to,	

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F 880	Continued From page 20 types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/29/22, at 2:38 p.m. R17 was noted to be laying on her back in bed, covered with a blue blanket up to her chin. R17's doorway continued to have signs, identifying contact and droplet precautions which identified an N95 was required to be worn. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/30/22, at 8:14 a.m. R17 was noted to be laying in bed on her back, eyes were closed and was covered with a blanket from her feet to her chin. At that time, nursing assistant (NA)-E and NA-C, entered R17's room and proceeded to assist R17 with morning cares. NA-E had on eye protection, a medical grade mask, gloves and a disposable gown, NA-C wore eye protection, an N95 mask, gloves and a disposable gown and both proceeded to assist R17 with morning cares. -at 8:38 a.m. licensed practical nurse (LPN)-C entered R17's room, she wore eye protection, an N95 mask, gloves and a disposable gown and proceeded to assist R17 to transfer from her bed to a tilt in space chair with a full mechanical lift with NA-E. NA-E remained wearing a medical grade mask. - at 8:42 a.m. NA-E left R17's room, removed his gloves, gown, medical grade mask, completed hand hygiene and donned a new medical grade mask.	F 880	transmission-based precautions, appropriate PPE use, and donning and doffing of PPE. Training included competency testing of staff which was documented via attestation statement of completion. Furthermore, education was provided to direct care staff related to overall catheter care, placement, and storage. 6. The DON, Infection Preventionist and/or designee will conduct real-time audits of donning/doffing PPE with transmission-based precautions on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Real time audits will also include aerosolized generating procedures and proper use of gowns to ensure PPE is in use. Audits will continue until 100% compliance is met on source control masking for staff, visitors, and residents. Audits will be reviewed at QAPI for review. Catheter care audits initiated on 5/2/22 to be completed and audited by the DON or designee three times weekly for four weeks, then weekly for one month. Audits will be reviewed at QAPI for review. 7. DON/Infection Preventionist/Designee responsible for compliance. 8. This deficiency will be corrected 5/2/22.	

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F 880	Continued From page 21 During an interview on 3/30/22, at 8:43 a.m. NA-E stated R17 was on contact and droplet precautions and indicated staff were to wear the following when entering her room; gown, gloves, eye protection and an N95 mask. NA-E stated he was not able to wear an N95 into R17's room, as there were none available. NA-E then moved to a four drawer plastic container outside of R17's room, pulled the second drawer open, revealed several dozen N95 masks. NA-E proceeded to pull the third drawer open, which revealed another several dozen N95 masks. NA-E indicated he had not checked the drawers before entering R17's room. During an interview on 3/30/22, at 12:37 a.m. NA-C stated R17 was currently on contact and droplet precautions due to a cough and other respiratory symptoms. NA-C indicated an N95 was required to be worn in R17's room, and changed to another mask, (medical grade if vaccinated and another N95 if unvaccinated) after leaving R17's room. During an interview on 3/30/22, at 1:05 p.m. LPN-B confirmed R17 was on contact and droplet precautions and staff were required to wear an N95 mask when in her room. LPN-B stated she did not notice what type of mask NA-E had on when R17's morning cares were provided. She indicated had she noticed NA-E had a medical grade mask on, she would have provided education and had him to change to an N95. During an interview on 3/31/22, at 8:37 a.m. the facility infection preventionist (IP) confirmed R17 had been placed on contact and droplet precautions due to respiratory symptoms and had	F 880		

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F 880	Continued From page 22 tested negative for COVID-19. The IP stated staff were required to wear an N95 in contact/droplet precaution rooms, along with gowns, gloves, and eye protection. R249 Review of R249's face sheet in the electronic health record (EHR), revealed R249 was admitted to the facility on 3/24/22. Review of R249's immunizations record in the EHR identified R249 was not up to date with all the recommended COVID-19 vaccine doses. Therefore, R249 was placed on Contact and Droplet Precautions upon admission. During an observation 3/29/22, at 11:12 a.m. of R249's room revealed signs on the door which read "Contact and Droplet Precautions." The signs indicated staff entering the room were to don (put on) eye protection, N95 mask, isolation gown, and gloves. The supplies for the staff to don prior to entering the room were located in a set of drawers outside the room. During an observation on 3/29/22, at 10:56 a.m., nursing assistant (NA)-D entered R249's room, with linens to make the bed in the room without wearing an isolation gown. During an interview on 3/29/22, at 10:56 a.m., NA-D verbalized she should have been wearing a gown when entering the room and confirmed she did not wear a gown when she was in R249's room. R245	F 880		

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F 880	Continued From page 23	F 880		

Review of R245's face sheet in the EHR, revealed R245 was admitted to the facility on 3/25/22.

Review of R245's immunizations record in the EHR revealed R245 was not up to date with all the recommended COVID-19 vaccine doses. Therefore, R245 was placed on Contact and Droplet Precautions upon admission.

During an observation on 3/28/22, at 4:45 p.m. R245's room had signs on the door which read "Contact and Droplet Precautions." The signs indicated staff entering the room were to don eye protection, N95 mask, isolation gown, and gloves. The supplies for the staff to don prior to entering the room were located in a set of drawers outside the room.

During an observation on 3/29/22, at 12:11 p.m., the Cook (C)-A was observed in R245's room serving R245 a lunch tray while not wearing a gown.

During an interview on 3/29/22, at 12:12 p.m., the director of nursing (DON) indicated she had observed C-A in R245's room serving the lunch tray without wearing an isolation gown. The DON confirmed C-A should have donned a gown prior to entering R245's room due to the resident being on Contact and Droplet isolation.

Review of the facility policy titled Admission, Transfers, and return from Outings for Residents during [the] COVID-19 Pandemic revised 2/12/22, identified upon admission and/or readmission residents who were not up to date with COVID-19 vaccinations would be placed on droplet and contact precautions for a period of 10 days.

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F 880	Continued From page 24 Review of the facility policy titled Isolation Precautions revised 6/23/20, identified transmission-based precautions would be used when transmission could not be reasonably prevented by standard precautions alone and the facility was expected to post clear signage on the door or wall outside of the resident room indicating the type of precautions and required personal protective equipment (PPE). Catheter Care R30's quarterly Minimum Data Set (MDS) dated 3/3/22, identified R30 had diagnoses which included dementia, bilateral above the knee amputations and obstructive uropathy. The MDS identified R30 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene and was totally dependent for bathing. The MDS identified R30 had an indwelling urinary catheter. R30's current physician orders revealed an order for a supra pubic catheter (surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow), catheter care every shift, cleanse tubing, catheter is anchored via Velcro or tape. R30's physician orders lacked direction on placement of the catheter collection bag. R30's current care plan revised 3/24/22, revealed R30 required a supra pubic catheter due to significant urinary retention and obstructive uropathy. The care plan lacked instructions for placement of R17's catheter collection bag.	F 880		

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F 880	Continued From page 25 During an observation on 3/28/22, at 5:18 p.m. R30 was noted to be laying on his back in low bed, his eyes were closed and he was covered with a blanket from his lower extremities to his mid chest. R30's catheter tubing was observed from underneath the blanket on the left side of his bed, and lead to a collection bag which laid directly on a fall mat on the floor. - at 6:49 p.m. R30 was observed to remain laying in bed on his back in a low bed (bed that is able to be lowered to ground level), his eyes were closed and he was covered with a blanket. R30's catheter collection bag remained laying directly on a fall mat on the floor. During an observation on 3/29/22, at 10:51 a.m. R30 was noted to be laying in bed on his back, in a low bed. R30's eyes were closed, he was covered with a blanket up to the top of his chest. R30's catheter collection bag was observed laying on the left side of his bed, directly on a fall mat on the floor. During an observation on 3/30/22, at 7:34 a.m. R30 was noted to be laying in bed on his back, in a low bed. R30's catheter collection bag was observed hanging off the left side of his bed, laying directly on a fall mat on the floor. - at 9:33 a.m. R30 was observed laying on his back in a low bed, his eyes were closed and he was covered with a blanket from his legs to his chest. R30's catheter collection bag, half full of yellow urine, was observed laying directly on a fall mat on the floor. - at 2:22 p.m. R30 was observed laying on his	F 880		

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F 880	Continued From page 26	F 880		

back in a low bed, his eyes were opened. R30's catheter collection bag was observed laying on the floor on the left side of his bed, no urine was observed in the bag, which lied directly on a fall mat on the floor.

During an interview on 3/30/22, at 2:23 p.m. NA-E stated R30 was totally dependent for all ADL's, which included dressing, personal hygiene and bathing. NA-E indicated R30 had a catheter, received catheter cares twice daily and indicated the collection bag was to be placed below R30's bladder, on the ground or underneath R30's wheelchair. NA-E was unaware of any cover used for R30's catheter collection bag.

During an interview on 3/30/22, at 2:40 p.m. licensed practical nurse (LPN)-A confirmed R30's catheter collection bag was laying directly on a fall mat on R30's floor. LPN- walked over to a chair in R30's room, and took hold of a black plastic bag. LPN-A opened the bag which revealed a black plastic catheter bag holder, she then took R30's catheter collection bag and placed it into the black bag and placed the catheter back on the left side of R30's bed. LPN-A stated she had brought the catheter bag cover into R30's room a few days ago. She indicated R30's low bed prevented the catheter collection bag from being completely off the floor, however the cover was needed to assist with infection control and for dignity.

During an interview on 3/31/22, at 8:46 a.m. the infection preventionist (IP) stated she would expect resident catheter collection bags to be placed in a cover and kept off the floor if at all possible. IP stated R30 had a low bed, which prevented the catheter from being off the floor,

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F 880	Continued From page 27 however she expected the collection bag to be covered to minimize possible infection control concerns. A facility policy titled, Foley Catheter Management, revised 11/4/20, identified catheter bags would be covered at all times.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 18, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 06P711

Dear Administrator:

The above facility was surveyed on March 28, 2022 through March 31, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00679	A. BUILDING: _____ B. WING _____	C 03/31/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/28/22, to 3/31/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. 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 surveyors 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 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance with routine grooming which included facial hair removal for 2 of 2 residents (R17 and R30) who required assistance with grooming and personal hygiene. Findings include: R17's quarterly Minimum Data Set (MDS) dated 2/10/22, identified R17 had diagnoses which included dementia, depression, and end stage renal disease. The MDS identified R17 had severe cognitive impairment, required extensive assistance with personal hygiene and was totally dependent for activities of daily living (ADL's) of dressing and bathing. The MDS revealed R17 had no rejection of cares during the seven day look back period. R17's care plan revised 1/26/22, identified R17	2 920	No POC required.	5/9/22

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2 920	Continued From page 3 had an ADL deficit, required assistance with dressing, bathing and personal hygiene. R17's care plan directed facility staff to check nail length and to attempt to trim and clean on bath day, as necessary and preferred to have long nails. R17's care plan lacked direction and preferences for facial hair removal. On 3/28/22, at 4:48 p.m. R17 was observed laying on her back in bed, eyes were closed, covered with a blanket from her feet to upper chest. R17 had several dozen, approximately five (5) to seven (7) millimeters (mm) long, white, wispy chin hairs and several dozen, two (2) to three (3) mm long, thick, course black hair along her chin, upper lip and corners of her mouth. On 3/29/22, at 9:45 a.m. R17 was observed seated in a tilt in space wheelchair (specialized wheelchair for positioning) in her room with her eyes closed. R17 faced the doorway, she had an over the bed, rolling table placed in front of her. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's hands rested on her lap, all ten of her fingernails were approximately 2-3 mm of length, were jagged, had chipped mauve colored nail polish and were observed to have a thick brownish substance underneath the length of all ten of her fingernails. - at 2:38 p.m. during an observation, R17 was laying on her back in bed, covered with a blue blanket up to her chin. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's hands rested on	2 920		

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2 920	Continued From page 4 her chest, all ten of her fingernails were approximately 2-3 mm of length, were jagged, had chipped mauve colored nail polish and were observed to have a thick brownish substance underneath the length of all ten of her fingernails. On 3/30/22, at 8:14 a.m. during an observation, R17 was laying in bed on her back, eyes were closed and was covered with a blanket from her feet to her chin. At that time, nursing assistant (NA)-E and NA-C, entered R17's room and proceeded to assist R17 with morning cares. R17 was assisted from her bed to a tilt in space wheelchair, NA-E proceeded to brush R17's hair. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. - at 9:46 a.m. during an observation, R17 remained seated in a tilt in space chair in her room with an over the bed table in front of her. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. - at 11:51 a.m. during an observation, R17 was seated in a tilt in space chair in her room, positioned to face the doorway. R17 continued to have dozens of approximately 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's	2 920		

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2 920	Continued From page 5 fingernails continued to be jagged, and had a thick brownish substance underneath the length of all ten fingernails. On 3/30/22, at 8:43 a.m. during an interview, NA-E indicated R17 was totally dependent for all ADL's, which included dressing, personal hygiene and bathing. NA-E indicated he did not feel R17 was able to verbalize her needs or wishes and staff were to anticipate her needs. NA-E stated he did not offer to remove R17's facial hair and did not attempt to provide nail care. NA-E indicated he was not aware of R17's preferences regarding facial hair removal and was not sure who was responsible for R17's nail care. On 3/30/22, at 12:37 p.m. during an interview, NA-C stated R17 was totally dependent for all of her ADL's of dressing, bathing, personal hygiene and all mobility. NA-C confirmed R17 was not offered to have her facial hair removed during morning cares and had not been offered since. NA-C indicated R17's nail were cleaned and filed on her bath day and as needed by other staff. NA-C stated she was not sure what the brown substance was underneath R17's nails and indicated she was not sure how long the substance had been underneath R17's fingernails. On 3/30/22, at 12:53 p.m. during an interview, licensed practical nurse (LPN)-B confirmed R17 had dozens of 5-7 mm long, white, wispy chin hairs and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. LPN-B also confirmed R17's fingernails were jagged, and had a thick brownish substance underneath the length of all ten fingernails. LPN-B stated she felt it would be important to R17 to be shaved daily and to have	2 920		

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2 920	Continued From page 6 her nails, neatly painted and filed. LPN-B indicated R17 used to take pride in her appearance prior to her dementia diagnosis. On 3/31/22, at 8:37 a.m. during an interview the assistant director of nursing (ADON) stated she felt R17 did not like anyone to touch her fingernails, preferred them long and felt it was difficult to keep her nails well manicured. The ADON stated she felt R17 likely had refused to have her facial hair removed, indicated the facility activity staff had been assisting with resident cares such as nail care, facial hair removal and other grooming and felt they were not aware of how to document resident refusals. The ADON stated she would expect R17 to be offered to shave daily and have her nail care provided as she would allow. On 3/31/22, at 9:23 a.m. during a telephone interview, R17's family member (FM)-A stated prior to R17's dementia diagnosis, she had taken pride in her overall appearance and had well manicured fingernails. FM-A indicated he had spoken to facility staff in the past year about concerns with R17's facial hair, nails and overall appearance. FM-A stated he expected R17 be assisted to remove her facial hair and be well groomed on a daily basis. On 3/31/22, at 9:27 a.m. during an interview, activity director (AD)-A stated R17 had been offered nail care and shaving on Monday, 3/28/22, and had refused. AD-A indicated she was unaware if R17 had been offered assistance with shaving or nail care on any days following her refusal. AD-A stated R17 had been assisted with shaving following interview with nursing staff on 3/30/22.	2 920		

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2 920	Continued From page 7 R30 R30's quarterly Minimum Data Set (MDS) dated 3/3/22, identified R30 had diagnoses which included dementia, anxiety and bilateral above the knee amputations. The MDS identified R30 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene and was totally dependent for bathing. The MDS identified R30 had no rejection of cares during the assessment period. R30's care plan revised 3/24/22, revealed R30 had an ADL self care deficit, required assistance with dressing, bathing, and personal hygiene. The care plan did not identify R30's facial hair or shaving preferences. On 3/28/22, at 5:12 p.m. during a telephone interview, R30's family member (FM)-B stated R30 liked to have a neat, clean appearance and would shave his facial hair daily. FM-B indicated R30 had a mustache oftentimes in the past, but did not have a beard, and liked to be clean shaven. FM-B indicated, a few months prior, R30's wife had voiced concerns about R30's appearance. She indicated R30's hair was unkept, he was unshaven and overall messy in appearance. FM-B indicated she had spoken to nursing and had not seen or heard any further concerns regarding R30's appearance since then. On 3/28/22, at 5:18 p.m. R30 was observed laying in bed on his back, his eyes closed and was covered with a blanket from his lower extremities up to his mid chest. R30's beard line was covered with thick, course, white/gray stubble approximately two (2) to three (3) millimeter (mm) long, along his cheeks, chin,	2 920		

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2 920	Continued From page 8 neck and upper lip. On 3/29/22, at 10:51 a.m. R30 was observed laying in bed on his back in a low bed, eyes closed and was covered with a blanket up to the top of his chest. R30 continued to have thick, course, white/gray facial stubble, approximately 2-3 mm long, along his cheeks, chin, neck and around his mouth. -at 3:46 p.m. R30 was observed seated in a tilt in space chair in his room and faced the window. R30 continued to have thick, course, white/gray facial stubble, approximately 2-3 mm long, along his cheeks, chin, neck and around his mouth. On 3/30/22, at 7:34 a.m. R30 was observed laying in his bed, on his back, eyes were closed and was covered with a blanket up to the top of his chest. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to four (4) mm long, along his cheeks, chin, neck and around his mouth. -at 11:44 a.m. R30 was observed seated in a tilt in space chair in the common area of the unit. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to 4 mm long, along his cheeks, chin, neck and around his mouth. - at 2:22 p.m. R30 was observed laying in bed on his back, his eyes were opened, he was covered with a blanket up to his chin. R30 continued to have thick, course, white/gray facial stubble, approximately 3 to four (4) mm long, along his cheeks, chin, neck and around his mouth. On 3/30/22, at 2:23 p.m. nursing assistant (NA)-E stated R30 was totally dependent for all ADL's,	2 920		

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2 920	Continued From page 9 which included dressing, personal hygiene and bathing. NA-E indicated R30 was shaved twice weekly and he had not shaved R30 in the past couple of days. On 3/30/22, at 2:40 p.m. licensed practical nurse (LPN)-A confirmed R30's facial hair, indicated it appeared R30 had not been shaved for a few days. LPN-A indicated R30 preferred to be clean shaven and should have been shaved daily. On 3/31/22, at 8:46 p.m. the facility administrator stated she felt R30 had refused shaving and routinely refused cares. The administrator indicated R30 historically was verbally aggressive with staff and could be very difficult to work with. She indicated she was not aware if staff were documenting R30's refusals, though would expect staff to document all refusals of care. On 3/31/22, at 9:30 a.m. the activity director (AD)-A stated R30 was approached on Monday, 3/28/22, and was offered shaving at that time. The AD-A indicated she was not aware if R30 had been offered to shave any other days during the week, but felt staff would assist if he allowed. A facility policy titled, Activities of Daily Living (ADL's) revised 3/15/21, identified based on assessment and resident needs and choices, the facility must provide the necessary care and services. The policy revealed the facility would provide the following ADL's, which included hygiene of bathing, dressing, grooming and oral cares. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to activities of daily living. The director of nursing	2 920		

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2 920	Continued From page 10 or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing assistance with activities of daily living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		5/9/22

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21390	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal protective equipment (PPE) was used when providing direct care for 3 of 5 residents (R17, R245 and R249) who were in droplet precautions. In addition, the facility failed to ensure resident catheter collection bag was stored in a manner to prevent infection for 1 of 2 residents (R30) reviewed for urinary catheters. Findings include: Transmission Based Precautions R17 R17's quarterly Minimum Data Set (MDS) dated 2/10/22, identified R17 had diagnoses which included dementia, depression, and end stage renal disease. The MDS identified R17 had severe cognitive impairment, required extensive assistance with personal hygiene and was totally dependent for activities of daily living (ADL's) with dressing and bathing. Review of R17's nursing progress notes dated 3/27/22, identified R17 had wheezing and required as needed inhalers for shortness of breath. A later note revealed R17 was placed on precautions for upper respiratory symptoms. During an observation on 3/28/22, at 4:48 p.m. R17 was noted to be laying on her back in bed, eyes were closed, covered with a blanket from her feet to upper chest. R17's door had a laminated eight (8) by 11 inch laminated sign which identified R17 was on contact and droplet	21390	No POC required.	

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	00679	A. BUILDING: _____ B. WING _____	C 03/31/2022

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21390	Continued From page 12 precautions, and revealed a mask, gown, eye wear and gloves were required to enter the room. A further laminated sign, identified an N95 mask was required for entry. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/29/22, at 10:21 a.m. R17 was seated in a tilt in space wheelchair in her room, had a wet cough and congestion in her throat she was unable to clear. R17's door to her room had contact and droplet precautions signs placed which identified an N95 was required to be worn. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/29/22, at 2:38 p.m. R17 was noted to be laying on her back in bed, covered with a blue blanket up to her chin. R17's doorway continued to have signs, identifying contact and droplet precautions which identified an N95 was required to be worn. A four drawer plastic container and a bedside table were also positioned outside of R17's room, which held a gloves, gowns, two types of N95 masks, medical grade masks and disinfecting wipes with instructions of use. During an observation on 3/30/22, at 8:14 a.m. R17 was noted to be laying in bed on her back, eyes were closed and was covered with a blanket from her feet to her chin. At that time, nursing assistant (NA)-E and NA-C, entered R17's room and proceeded to assist R17 with morning cares.	21390		

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21390	Continued From page 13 NA-E had on eye protection, a medical grade mask, gloves and a disposable gown, NA-C wore eye protection, an N95 mask, gloves and a disposable gown and both proceeded to assist R17 with morning cares. -at 8:38 a.m. licensed practical nurse (LPN)-C entered R17's room, she wore eye protection, an N95 mask, gloves and a disposable gown and proceeded to assist R17 to transfer from her bed to a tilt in space chair with a full mechanical lift with NA-E. NA-E remained wearing a medical grade mask. - at 8:42 a.m. NA-E left R17's room, removed his gloves, gown, medical grade mask, completed hand hygiene and donned a new medical grade mask. During an interview on 3/30/22, at 8:43 a.m. NA-E stated R17 was on contact and droplet precautions and indicated staff were to wear the following when entering her room; gown, gloves, eye protection and an N95 mask. NA-E stated he was not able to wear an N95 into R17's room, as there were none available. NA-E then moved to a four drawer plastic container outside of R17's room, pulled the second drawer open, revealed several dozen N95 masks. NA-E proceeded to pull the third drawer open, which revealed another several dozen N95 masks. NA-E indicated he had not checked the drawers before entering R17's room. During an interview on 3/30/22, at 12:37 a.m. NA-C stated R17 was currently on contact and droplet precautions due to a cough and other respiratory symptoms. NA-C indicated an N95 was required to be worn in R17's room, and changed to another mask, (medical grade if	21390		

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21390	Continued From page 14 vaccinated and another N95 if unvaccinated) after leaving R17's room. During an interview on 3/30/22, at 1:05 p.m. LPN-B confirmed R17 was on contact and droplet precautions and staff were required to wear an N95 mask when in her room. LPN-B stated she did not notice what type of mask NA-E had on when R17's morning cares were provided. She indicated had she noticed NA-E had a medical grade mask on, she would have provided education and had him to change to an N95. During an interview on 3/31/22, at 8:37 a.m. the facility infection preventionist (IP) confirmed R17 had been placed on contact and droplet precautions due to respiratory symptoms and had tested negative for COVID-19. The IP stated staff were required to wear an N95 in contact/droplet precaution rooms, along with gowns, gloves, and eye protection. R249 Review of R249's face sheet in the electronic health record (EHR), revealed R249 was admitted to the facility on 3/24/22. Review of R249's immunizations record in the EHR identified R249 was not up to date with all the recommended COVID-19 vaccine doses. Therefore, R249 was placed on Contact and Droplet Precautions upon admission. During an observation 3/29/22, at 11:12 a.m. of R249's room revealed signs on the door which read "Contact and Droplet Precautions." The signs indicated staff entering the room were to don (put on) eye protection, N95 mask, isolation gown, and gloves. The supplies for the staff to	21390		

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21390	Continued From page 15 don prior to entering the room were located in a set of drawers outside the room. During an observation on 3/29/22, at 10:56 a.m., nursing assistant (NA)-D entered R249's room, with linens to make the bed in the room without wearing an isolation gown. During an interview on 3/29/22, at 10:56 a.m., NA-D verbalized she should have been wearing a gown when entering the room and confirmed she did not wear a gown when she was in R249's room. R245 Review of R245's face sheet in the EHR, revealed R245 was admitted to the facility on 3/25/22. Review of R245's immunizations record in the EHR revealed R245 was not up to date with all the recommended COVID-19 vaccine doses. Therefore, R245 was placed on Contact and Droplet Precautions upon admission. During an observation on 3/28/22, at 4:45 p.m. R245's room had signs on the door which read "Contact and Droplet Precautions." The signs indicated staff entering the room were to don eye protection, N95 mask, isolation gown, and gloves. The supplies for the staff to don prior to entering the room were located in a set of drawers outside the room. During an observation on 3/29/22, at 12:11 p.m., the Cook (C)-A was observed in R245's room serving R245 a lunch tray while not wearing a gown.	21390		

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21390	Continued From page 16 During an interview on 3/29/22, at 12:12 p.m., the director of nursing (DON) indicated she had observed C-A in R245's room serving the lunch tray without wearing an isolation gown. The DON confirmed C-A should have donned a gown prior to entering R245's room due to the resident being on Contact and Droplet isolation. Review of the facility policy titled Admission, Transfers, and return from Outings for Residents during [the] COVID-19 Pandemic revised 2/12/22, identified upon admission and/or readmission residents who were not up to date with COVID-19 vaccinations would be placed on droplet and contact precautions for a period of 10 days. Review of the facility policy titled Isolation Precautions revised 6/23/20, identified transmission-based precautions would be used when transmission could not be reasonably prevented by standard precautions alone and the facility was expected to post clear signage on the door or wall outside of the resident room indicating the type of precautions and required personal protective equipment (PPE). Catheter Care R30's quarterly Minimum Data Set (MDS) dated 3/3/22, identified R30 had diagnoses which included dementia, bilateral above the knee amputations and obstructive uropathy. The MDS identified R30 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of dressing, personal hygiene and was totally dependent for bathing. The MDS identified R30 had an indwelling urinary catheter. R30's current physician orders revealed an order	21390		

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21390	Continued From page 17	21390		

for a supra pubic catheter (surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow), catheter care every shift, cleanse tubing, catheter is anchored via Velcro or tape. R30's physician orders lacked direction on placement of the catheter collection bag.

R30's current care plan revised 3/24/22, revealed R30 required a supra pubic catheter due to significant urinary retention and obstructive uropathy. The care plan lacked instructions for placement of R17's catheter collection bag.

During an observation on 3/28/22, at 5:18 p.m. R30 was noted to be laying on his back in low bed, his eyes were closed and he was covered with a blanket from his lower extremities to his mid chest. R30's catheter tubing was observed from underneath the blanket on the left side of his bed, and lead to a collection bag which laid directly on a fall mat on the floor.

- at 6:49 p.m. R30 was observed to remain laying in bed on his back in a low bed (bed that is able to be lowered to ground level), his eyes were closed and he was covered with a blanket. R30's catheter collection bag remained laying directly on a fall mat on the floor.

During an observation on 3/29/22, at 10:51 a.m. R30 was noted to be laying in bed on his back, in a low bed. R30's eyes were closed, he was covered with a blanket up to the top of his chest. R30's catheter collection bag was observed laying on the left side of his bed, directly on a fall mat on the floor.

During an observation on 3/30/22, at 7:34 a.m.

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21390	Continued From page 18 R30 was noted to be laying in bed on his back, in a low bed. R30's catheter collection bag was observed hanging off the left side of his bed, laying directly on a fall mat on the floor. - at 9:33 a.m. R30 was observed laying on his back in a low bed, his eyes were closed and he was covered with a blanket from his legs to his chest. R30's catheter collection bag, half full of yellow urine, was observed laying directly on a fall mat on the floor. - at 2:22 p.m. R30 was observed laying on his back in a low bed, his eyes were opened. R30's catheter collection bag was observed laying on the floor on the left side of his bed, no urine was observed in the bag, which lied directly on a fall mat on the floor. During an interview on 3/30/22, at 2:23 p.m. NA-E stated R30 was totally dependent for all ADL's, which included dressing, personal hygiene and bathing. NA-E indicated R30 had a catheter, received catheter cares twice daily and indicated the collection bag was to be placed below R30's bladder, on the ground or underneath R30's wheelchair. NA-E was unaware of any cover used for R30's catheter collection bag. During an interview on 3/30/22, at 2:40 p.m. licensed practical nurse (LPN)-A confirmed R30's catheter collection bag was laying directly on a fall mat on R30's floor. LPN- walked over to a chair in R30's room, and took hold of a black plastic bag. LPN-A opened the bag which revealed a black plastic catheter bag holder, she then took R30's catheter collection bag and placed it into the black bag and placed the catheter back on the left side of R30's bed. LPN-A stated she had brought the catheter bag cover into R30's room a	21390		

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21390	Continued From page 19 few days ago. She indicated R30's low bed prevented the catheter collection bag from being completely off the floor, however the cover was needed to assist with infection control and for dignity. During an interview on 3/31/22, at 8:46 a.m. the infection preventionist (IP) stated she would expect resident catheter collection bags to be placed in a cover and kept off the floor if at all possible. IP stated R30 had a low bed, which prevented the catheter from being off the floor, however she expected the collection bag to be covered to minimize possible infection control concerns. A facility policy titled, Foley Catheter Management, revised 11/4/20, identified catheter bags would be covered at all times. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review and revise policies and procedures related to ensuring transmission based precautions were followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are following guidance with personal protection equipment with identified transmission based precautions. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21390		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged.	21925		5/9/22

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21925	Continued From page 20 Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and review, the facility failed to notify the State Ombudsman's office of a facility transfer for one of two residents (R8) reviewed for transfers. Findings include: Review of the R8's form titled Face Sheet revealed R8 was admitted to the facility on 7/23/21, and readmitted on 1/31/22. Review of R8's progress notes from 1/30/22, to 1/31/22, revealed the following: -1/30/22, at 2:50 p.m. identified the ambulance	21925	No POC required.	

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21925	Continued From page 21	21925		

arrived at the facility and transported R8 to the emergency room due to R8's altered cognition. -1/31/22, at 6:50 p.m. R8 had been re-admitted to the hospital.

Review of the Ombudsman notifications for the month of January and February 2022, revealed no documentation the Ombudsman had been notified about R8's transfer to the hospital.

During an interview on 3/30/22, at 3:10 p.m., the Social Service Director (SSD) indicated the process for notification of the Ombudsman was to fax, at the beginning of the month, a list of residents transferred or discharged from the facility during the previous month. SSD confirmed review of the notifications for the month of January 2022, and February 2022, revealed the Ombudsman had been notified that R8 was transferred to the hospital.

During an interview on 3/30/22, at 3:15 p.m., the Minimum Data Set (MDS) Coordinator confirmed R8 was discharged from the facility on 1/30/22, at 2:50 p.m. and returned to the facility the next day, on 1/31/22, at 6:40 p.m.

During an interview on 3/30/22, at 3:20 p.m., the administrator stated the expectation was staff were to fax the Ombudsman the list of residents discharged on a monthly basis even if the resident had only been gone for one day. The administrator confirmed the notification of the discharge of R8 on 1/30/22, had not been communicated to the Ombudsman.

Review of the facility policy titled Admission, Readmission, Bed Hold, and Transfer/Discharge dated 1/04/19, revealed a copy of the [discharge] notice must be sent to a representative of the

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21925	Continued From page 22 Office of the State Long-Term Care Ombudsman. SUGGESTED METHOD OF CORRECTION: The Director of Social Services or designee could develop, review, and/or revise policies and procedures to ensure the ombudsman received notification of all hospitalizations. The Director of Social Services or designee could educate all appropriate staff on the policies and procedures. The Director of Social Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		

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	245581	A. BUILDING **01 - DINING ADDITION 01** B. WING _____	**03/29/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/29/2022. At the time of this survey, Fair Oaks Nursing & Rehab-Bldg 01 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Fair Oaks Nursing & Rehab was constructed at four different times. In 1995 the kitchen and dining building 02 was constructed to the west of the 1965 building and is a 2-story addition that was determined to be of Type IV(2HH) construction. It is separated by a 10-foot enclosed walkway and a 2-hour fire barrier. No sleeping rooms are in this building. The original building (01 Main Building) was constructed in 1965, was determined to be of Type II (222) construction, and has a wood roof system that meets NFPA 101 Sec 19.1.6.2. In 1972 a 3-story addition was constructed to the east of the original building that is a 3-story building; no basement was determined to be of Type II (222) construction, and it has a wood roof system that meets NFPA 101 Sec 19.1.6.2. In 1976, a 2-story addition was constructed to the south that was determined to be of Type II(222) construction. The facility was surveyed as two buildings. The facility is completely sprinkler protected with a dry pipe system and a wet pipe system. The facility has smoke detection in the corridor	K 000		

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

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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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
K 000	Continued From page 1 system, in all areas open to the corridor, in all common areas, and in all sleeping rooms that are on the facility's fire alarm system that has automatic fire department notification. The facility has a capacity of 75 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**03/29/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/29/2022. At the time of this survey, Fair Oaks Nursing & Rehab-Bldg 02 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Fair Oaks Nursing & Rehab was constructed at four different times. In 1995 the kitchen and dining building 02 was constructed to the west of the 1965 building and is a 2-story addition that was determined to be of Type IV(2HH) construction. It is separated by a 10-foot enclosed walkway and a 2-hour fire barrier. No sleeping rooms are in this building. The original building (01 Main Building) was constructed in 1965, was determined to be of Type II (222) construction, and has a wood roof system that meets NFPA 101 Sec 19.1.6.2. In 1972 a 3-story addition was constructed to the east of the original building that is a 3-story building with no basement and was determined to be of Type II (222) construction and has a wood roof system that meets NFPA 101 Sec 19.1.6.2. In 1976, a 2-story addition was constructed to the south that was determined to be of Type II(222) construction. The facility was surveyed as two buildings. The facility is completely sprinkler protected with a dry pipe system and a wet pipe system. The facility has smoke detection in the corridor	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**03/29/2022**

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