

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 Therefore, the NATCEP prohibition is rescinded.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 <a href="mailto:Tamika.Brown@cms.hhs.gov">Tamika.Brown@cms.hhs.gov</a>.

#### 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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc">https://mdhprovidercontent.web.health.state.mn.us/ltc</a> 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

PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		045504				С	
		245581	B. WING			03/	31/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	AB LLC			201 SHADY LANE DRIVE		
					WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	000			
	with Appendix Z, Er Requirements, §48	1/22, a survey for compliance mergency Preparedness 3.73(b)(6) was conducted ecertification survey. The bliance.					
F 000	signature is not req page of the CMS-29 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.	F 0	000			
	survey was conductinvestigation was alwas found to be Norequirements of 42	1/22, a standard recertification ted at your facility. A complaint lso conducted. Your facility OT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.					
	UNSUBSTANTIATE	810 and MN80869),					
	as your allegation of Departments acception enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required the first page of the CMS-2567 ic submission of the POC will tion of compliance.					
MD05:70-7	onsite revisit of you validate that substa regulations has bee	acceptable electronic POC, an r facility may be conducted to intial compliance with the an attained.	IATURE.		TITLE		(VC) DATE
LABORATOR\	Y DIRECTOR'S OR PROVID	JEK/SUPPLIER REPRESENTATIVE'S SIGN	MAIURE		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:	` '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		045504				С	
		245581	B. WING		03	/31/2022	
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 623 SS=D	CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility trar resident, the facility (i) Notify the resider representative(s) of the reasons for the language and mann facility must send a representative of th Long-Term Care Or (ii) Record the reas discharge in the res accordance with pa and (iii) Include in the no paragraph (c)(5) of §483.15(c)(4) Timir (i) Except as specif (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be no before transfer or d (A) The safety of in be endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's h allow a more immed under paragraph (c (D) An immediate to required by the resi	e before transfer. Insfers or discharges a must- Int and the resident's of the transfer or discharge and move in writing and in a mer they understand. The copy of the notice to a le office of the State mbudsman. In ons for the transfer or sident's medical record in largraph (c)(2) of this section; of the notice in this section.  In g of the notice. In g of the notice of transfer or under this section must be lat least 30 days before the led or discharged. In made as soon as practicable	F6	623		5/9/22	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ID PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245581	B. WING			C <b>3/31/2022</b>
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS NURSING & REHAB LLC				STREET ADDRESS, CITY, STATE, ZIP COI 201 SHADY LANE DRIVE WADENA, MN 56482		0/0 1/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 623	(E) A resident has ridays.  §483.15(c)(5) Continotice specified in produce the foliation of the foliation in the reason for the foliation in the effective data (iii) The effective data (iii) The location to transferred or dischedive to a statement of the including the name, and telephone number of the completing the form hearing request;  (v) The name, address and developmental disabilities, the maintelephone number of the protection and a developmental disabilities, the maintelephone number of the protection and a developmental disabilities, the maintelephone number of the protection and a developmental disabilities, the maintelephone number of the protection and a developmental disabilities of the Developmental disabilities of the Developmental disabilities and Bill of Rights Accodified at 42 U.S.C. (vii) For nursing factories and address and agency responsible advocacy of individual control of the disabilities.	ents of the notice. The written paragraph (c)(3) of this section lowing: ransfer or discharge; the of transfer or discharge; which the resident is arged; which the resident is arged; the resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State mbudsman; lity residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with bilities established under Part ental Disabilities Assistance of 2000 (Pub. L. 106-402, C. 15001 et seq.); and ility residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder the Protection and Advocacy iduals Act.	F6	523		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		245581	B. WING			C <b>03/31/2022</b>	
	PROVIDER OR SUPPLIER  KS NURSING & REH	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 623	If the information in effecting the transfer must update the reas practicable once becomes available.  §483.15(c)(8) Notice In the case of facility the administrator of written notification in to the State Survey State Long-Term Content to the facility, and the well as the plan for relocation of the reast 483.70(l). This REQUIREMED by:  Based on interview to notify the State Confacility transfer for contraviewed for transfer for the reviewed for transfer for the review of the R8's revealed R8 was at 7/23/21, and readminute for the review of R8's properties of R8's properties for the facility emergency room decrease of the facility emergency room decrease of the facility emergency room decrease of the Ombotics	the notice changes prior to be or discharge, the facility cipients of the notice as soon at the updated information  be in advance of facility closure by closure, the individual who is if the facility must provide prior to the impending closure. Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at §  NT is not met as evidenced of and review, the facility failed ombudsman's office of a one of two residents (R8) ers.  form titled Face Sheet dmitted to the facility on nitted on 1/31/22.	F6	F623- D Notice Requirements Transfer/Discharge The facility failed to notify the Ombudsman of a facility transf resident who was hospitalized returned to the facility.  1. F623 2. The ombudsman was notif resident □s transfer to the hosp (1/30/22) and readmission to F (1/31/22) on 3/30/22. All reside have been transferred within the months were reviewed to ensu notifications were sent to the Otimely.  3. All residents are at risk of the affected by this deficient practicular to the procedure of transferring and social services designee resident procedure of transferring and social services designee resident.	er for one but ied of the ital OL nts who le last three re that imbudsman being ce. ing staff elated to		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245581	B. WING		C 03/31/2022	
NAME OF F	PROVIDER OR SUPPLIER	240001		TREET ADDRESS, CITY, STATE, ZIP CODE	03/31	12022
NAME OF F	TOVIDER OR SUFFEIER			01 SHADY LANE DRIVE		
FAIR OA	KS NURSING & REHA	AB LLC		VADENA, MN 56482		
1				·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 623	Continued From pa	ge 4	F 623			
		he Ombudsman had been transfer to the hospital.		out of point click care when he or s sent to the hospital and sending the	e	
	During an interview	on 3/30/22, at 3:10 p.m., the		proper notification to the Ombudsm 5. Audits initiated 4/21/22 to be	ıan.	
		ctor (SSD) indicated the		completed and audited by the DON	lor	
		tion of the Ombudsman was to		designee two times weekly for four		
		g of the month, a list of		then every week for four weeks. Au		
		ed or discharged from the		will be reviewed at QAPI for additio		
		revious month. SSD confirmed ations for the month of		oversight and possible changes ne ensure ongoing compliance.	eded to	
		February 2022, revealed the		DON/designee will be responsitely	ble for	
		een notified that R8 was		compliance.		
	transferred to the h	ospital.		7. This deficiency will be correcte	d	
	During an interview	on 3/30/22, at 3:15 p.m., the		5/9/22.		
		(MDS) Coordinator confirmed				
		from the facility on 1/30/22, at				
		ned to the facility the next day,				
	on 1/31/22, at 6:40	p.m.				
		on 3/30/22, at 3:20 p.m., the				
		the expectation was staff				
		budsman the list of residents				
		onthly basis even if the een gone for one day. The				
		med the notification of the				
	discharge of R8 on	1/30/22, had not been				
	communicated to the	ne Ombudsman.				
	Review of the facilit	ry policy titled Admission,				
		Hold, and Transfer/Discharge				
	dated 1/04/19, reve	aled a copy of the [discharge]				
		t to a representative of the				
T 055		_ong-Term Care Ombudsman.	L 0EC		_	10122
	Baseline Care Plan CFR(s): 483.21(a)(		F 655		5/	/9/22
00-0	51 11(5). 400.21(a)(	., (=)				
	§483.21 Comprehe	nsive Person-Centered Care				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245581	B. WING		C 03/31/2022		
	PROVIDER OR SUPPLIER  KS NURSING & REH	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 655	implement a baselii that includes the inseffective and perso that meet profession. The baseline care p(i) Be developed with admission.  (ii) Include the minimal necessary to prope including, but not lir (A) Initial goals base (B) Physician order (C) Dietary orders.  (D) Therapy services.  (E) Social services.  (F) PASARR recommed systems (E) Social services.  (F) PASARR recommed systems (F) PASARR recommed services.  (i) Is developed with admission.  (ii) Meets the require (b) of this section (e) this section (e) this section (e) this section (e) the baseline care limited to:  (i) The initial goals (ii) A summary of the dietary instructions.  (iii) Any services and the inservices and the instructions.  (iii) Any services and the inservices and the instructions.  (iii) Any services and the inservices and the instructions.	e Care Plans facility must develop and ne care plan for each resident structions needed to provide n-centered care of the resident nal standards of quality care. plan must- thin 48 hours of a resident's mum healthcare information rly care for a resident mited to- ed on admission orders. s.  es.  mendation, if applicable. facility may develop a e plan in place of the baseline hprehensive care plan- thin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the expresentative with a summary e plan that includes but is not of the resident. The resident's medications and	F 65	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245581	B. WING _		C <b>03/31/2022</b>	
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 655	on behalf of the fact (iv) Any updated inf of the comprehensi This REQUIREMEN by: Based on interview facility failed to ensicompleted within 48 of four residents (R care plans.  Findings include: Review of R245's fa admitted to the facily which included sepsinjury), osteomyeliti right ankle, and a cleg.  Review of R245's b first two sections, Grunctional Status with The following six sections of Functional Status with following six sections or family representation of the form lacked signor family representation of the form lacked signor family representations within 48-hou confirmed R245's been completed.  Review of the facility	ility. ormation based on the details we care plan, as necessary. NT is not met as evidenced and document review, the are a baseline care plan was 3-hours of admission for one 245 reviewed for baseline  ace sheet revealed R245 was atty on 3/25/22, with diagnoses is (infection causing tissue infection of the bone) of the arenic ulcer to the lower left aseline care plan identified the arenal Information and are completed on 3/25/22. Activities, and (BCP) Summary and been completed. Additionally, natures from the resident and attive.  on 3/31/22, at 9:50 a.m., the foursing (ADON) stated staff complete the baseline care ris of admission. ADON aseline care plan had not	F 65	F655- D Baseline Care Plan Facility failed to ensure a baseline plan was completed within 48 hour admission for one resident.  1. F655 2. Baseline care plan for R 245 completed 3/29/22. All residents w admitted within the last week were reviewed to ensure that his or her baseline care plans have been cor timely. 3. All residents are at risk of bein affected by this deficient practice. 4. Education provided to nursing social services designee, therapy of activity director and dietary manag 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 designee one time weekly for four then every other week for one mor Audits will be reviewed at QAPI for additional oversight and possible of needed to ensure ongoing complia 6. DON/designee will be respons compliance. 7. This deficiency will be corrected 5/9/22.	ho have holeted g staff, director, er  Nor weeks, hanges ince. ible for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245581	B. WING		C <b>03/31/2022</b>	
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  201 SHADY LANE DRIVE  WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655 F 677 SS=D	developed within 48 ADL Care Provided	baseline care plan would be hours of admission. for Dependent Residents	F 65			5/9/22
	out activities of daily services to maintain personal and oral harmonic personal and observation review the facility faroutine grooming was removal for 2 of 2 required assistance hygiene.  Findings include:  R17's quarterly Min 2/10/22, identified Fincluded dementia, renal disease. The severe cognitive im assistance with perdependent for activity dressing and bathin had no rejection of look back period.  R17's care plan reviad an ADL deficit, dressing, bathing a care plan directed fand to attempt to trinecessary and prefixed.	ident who is unable to carry y living receives the necessary in good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview and document hiled to provide assistance with hich included facial hair residents (R17 and R30) who is with grooming and personal with depression, and end stage MDS identified R17 had pairment, required extensive sonal hygiene and was totally ities of daily living (ADL's) of the MDS revealed R17 cares during the seven day issed 1/26/22, identified R17 required assistance with and personal hygiene. R17's acility staff to check nail length im and clean on bath day, as erred to have long nails. R17's rection and preferences for		F677- D ADL Care Provided for Dependent Residents Facility failed to provide assistance routine grooming which included fact hair removal for two residents who required assistance with grooming a personal hygiene.  1. F667 2. Facial hair was shaved, and fingernails were cleansed and trimin R17 and R30. All other residents assessed for shaving needs and shas required. All residents are at risk being affected by this deficient practice. 3. All residents are at risk of being affected by this deficient practice. 4. Education provided to nursing sand activity staff related to the import shaving per resident sneeds or desires. 5. Audits initiated 4/21/22 to be completed and audited by the DON designee three times weekly for four weeks, then weekly for one month. will be reviewed at QAPI for review audits determine whether the residents.	med for naved cofestice. Staff ortance or ur Audits	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245581	B. WING			C <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA	21000		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		31/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	laying on her back is covered with a blanchest. R17 had sev (5) to seven (7) mill wispy chin hairs and three (3) mm long, her chin, upper lip at On 3/29/22, at 9:45 seated in a tilt in sp wheelchair for positive eyes closed. R17 for over the bed, rolling R17 continued to he 5-7 mm long, white dozen 2-3 mm long along her chin, upper mouth. R17's handsher fingernails were length, were jagged nail polish and were brownish substance ten of her fingernail.  - at 2:38 p.m. during laying on her back is blanket up to her chozens of approxim wispy chin hairs and thick, black, course and corners of her inher chest, all ten or approximately 2-3 rinad chipped mauve observed to have a	p.m. R17 was observed n bed, eyes were closed, ket from her feet to upper eral dozen, approximately five imeters (mm) long, white, d several dozen, two (2) to thick, course black hair along and corners of her mouth.  a.m. R17 was observed ace wheelchair (specialized ioning) in her room with her aced the doorway, she had an a table placed in front of her. ave dozens of approximately, wispy chin hairs and several, thick, black, course hairs er lip and corners of her is rested on her lap, all ten of approximately 2-3 mm of l, had chipped mauve colored to observed to have a thick a underneath the length of all	F 6	was shaved, if they refused to if their care plan was updated to her preference in shaving, if than every day.  6. DON/designee will be resp compliance.  7. This deficiency will be corres/9/22.	o reflect his different onsible for	

	PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   (X2) MULTIPLE CONSTRUCTION   A. BUILDING		COMPLETED			
		245581	B. WING			C <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482	1 00/	0 112022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 677	R17 was laying in b closed and was covered feet to her chin. At the (NA)-E and NA-C, or proceeded to assist was assisted from high wheelchair, NA-E proceeded to assist was assisted from high wheelchair, NA-E proceeded to have assisted from high wheelchair, NA-E proceeded to have assisted from high layer and long, white dozen 2-3 mm long along her chin, upper and had a thick brown that have a thick brown that are chin, upper and had a thick brown that length of all ten and had a thick brown that length of all te	a.m. during an observation, ed on her back, eyes were vered with a blanket from her that time, nursing assistant entered R17's room and to R17 with morning cares. R17 her bed to a tilt in space roceeded to brush R17's hair. ave dozens of approximately, wispy chin hairs and several, thick, black, course hairs er lip and corners of her mails continued to be jagged, which substance underneath fingernails.  If an observation, R17 a tilt in space chair in her he bed table in front of her. ave dozens of approximately, wispy chin hairs and several, thick, black, course hairs er lip and corners of her mails continued to be jagged, which substance underneath fingernails.  In gan observation, R17 was ace chair in her room, he doorway. R17 continued to be pagged, which substance underneath fingernails.  In gan observation, R17 was ace chair in her room, he doorway. R17 continued to be pagged, and several dozen 2-3 mm ourse hairs along her chin, rs of her mouth. R17's d to be jagged, and had a stance underneath the length	F6	577		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245581	B. WING			C <b>31/2022</b>	
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE	
F 677	NA-E indicated R17 ADL's, which include and bathing. NA-E is was able to verbaliz staff were to anticiped did not offer to remend attempt to provide was not aware of facial hair removal a responsible for R17 On 3/30/22, at 12:3 NA-C stated R17 wher ADL's of dressin and all mobility. NA offered to have her morning cares and NA-C indicated R17 on her bath day and NA-C stated she was substance was und indicated she was resubstance had been fingernails.  On 3/30/22, at 12:5 licensed practical in had dozens of 5-7 rhairs and several deblack, course hairs corners of her mout R17's fingernails we brownish substance ten fingernails. LPN important to R17 to	a.m. during an interview, was totally dependent for all ed dressing, personal hygiene indicated he did not feel R17 be her needs or wishes and ate her needs. NA-E stated he ove R17's facial hair and did de nail care. NA-E indicated if R17's preferences regarding and was not sure who was 's nail care.  7 p.m. during an interview, as totally dependent for all of ng, bathing, personal hygiene -C confirmed R17 was not facial hair removed during had not been offered since. T's nail were cleaned and filed d as needed by other staff. as not sure what the brown erneath R17's nails and not sure how long the	F 6	77			
	indicated R17 used appearance prior to	to take pride in her her dementia diagnosis.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245581	B. WING		C 03/31/2022	
NAME OF F	PROVIDER OR SUPPLIER	240001		STREET ADDRESS, CITY, STATE, ZIP CODE	03/3	31/2022
FAIR OA	FAIR OAKS NURSING & REHAB LLC			201 SHADY LANE DRIVE WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	assistant director of felt R17 did not like fingernails, preferred difficult to keep her ADON stated she fel have her facial hair activity staff had be cares such as nail cother grooming and how to document restated she would explay and have she would allow.  On 3/31/22, at 9:23 interview, R17's famprior to R17's demorpride in her overall manicured fingernal spoken to facility state concerns with R17's appearance. FM-A assisted to remove groomed on a daily On 3/31/22, at 9:27 activity director (AD offered nail care an 3/28/22, and had rewas unaware if R17 with shaving or nail her refusal. AD-A states.	a.m. during an interview the foursing (ADON) stated she anyone to touch here determined them long and felt it was nails well manicured. The left R17 likely had refused to removed, indicated the facility en assisting with resident care, facial hair removal and felt they were not aware of esident refusals. The ADON expect R17 to be offered to be her nail care provided as a.m. during a telephone of the had aff in the past year about a facial hair, nails and overall stated he expected R17 be her facial hair and be well	F 67	7		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED		
		245581	B. WING					C 31/2022
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDR 201 SHADY L WADENA, M		DDE	007	0172022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF COR CH CORRECTIVE ACTION S-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 677	3/3/22, identified R3 included dementia, the knee amputation had severe cognitive extensive assistance (ADL's) of dressing totally dependent for R30 had no rejection assessment period R30's care plan revelocated had an ADL self care with dressing, bathic care plan did not identificate plan did not have a would shave his fact R30 liked to have a would shave his fact R30 had a mustach did not have a bear shaven. FM-B indice R30's wife had voice appearance. She in unkept, he was unsappearance. FM-B nursing and had no concerns regarding On 3/28/22, at 5:18 laying in bed on his was covered with a extremities up to his was covered with the stubble approximate.	imum Data Set (MDS) dated 30 had diagnoses which anxiety and bilateral above ns. The MDS identified R30 re impairment and required with activities of daily living personal hygiene and was or bathing. The MDS identified on of cares during the rised 3/24/22, revealed R30 re deficit, required assistance ng, and personal hygiene. The entify R30's facial hair or	F	77				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245581	B. WING		03	C /31/2022	
	PROVIDER OR SUPPLIER  KS NURSING & REH			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		10 1/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 677	laying in bed on his closed and was covered white properties of the state of the st	age 13  31 a.m. R30 was observed back in a low bed, eyes wered with a blanket up to the 30 continued to have thick, facial stubble, approximately 19 his cheeks, chin, neck and was observed seated in a tilt in 19 com and faced the window. The area were elementary oximately 2-3 mm long, along eck and around his mouth.  4 a.m. R30 was observed in his back, eyes were closed with a blanket up to the top of tinued to have thick, course, subble, approximately 3 to four his cheeks, chin, neck and was observed seated in a tilt in 19 common area of the unit. The area were opened, he was covered to his chin. R30 continued to white/gray facial stubble, four (4) mm long, along his and around his mouth.  3 p.m. nursing assistant (NA)-Eally dependent for all ADL's, ally dependent for all ADL's,	F6	777			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245581	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER	243301	5		FREET ADDRESS, CITY, STATE, ZIP CODE	03/-	31/2022
FAID OA	KC NUDCINO O DELLA	AD I I O			1 SHADY LANE DRIVE		
FAIR OA	KS NURSING & REHA	AR FFC		W	ADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677			F 6	577			
	bathing. NA-E indic	ssing, personal hygiene and tated R30 was shaved twice not shaved R30 in the past					
	(LPN)-A confirmed appeared R30 had days. LPN-A indicate	p.m. licensed practical nurse R30's facial hair, indicated it not been shaved for a few ted R30 preferred to be clean have been shaved daily.					
	stated she felt R30 routinely refused ca indicated R30 histo with staff and could She indicated she v	p.m. the facility administrator had refused shaving and ares. The administrator rically was verbally aggressive be very difficult to work with was not aware if staff were refusals, though would expect II refusals of care.					
	(AD)-A stated R30 v 3/28/22, and was of The AD-A indicated been offered to sha	a.m. the activity director was approached on Monday, ffered shaving at that time. I she was not aware if R30 had ave any other days during the would assist if he allowed.					
	(ADL's) revised 3/1 assessment and re facility must provide services. The policy provide the followin	d, Activities of Daily Living 5/21, identified based on sident needs and choices, the e the necessary care and y revealed the facility would g ADL's, which included dressing, grooming and oral					
F 695 SS=D	Respiratory/Trache	ostomy Care and Suctioning	F 6	95			5/9/22

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245581	B. WING				31/ <b>2022</b>
NAME OF I	PROVIDER OR SUPPLIER	210001	I		FREET ADDRESS, CITY, STATE, ZIP CODE	03/	31/2022
FAIR OA	KS NURSING & REH	AB LLC			01 SHADY LANE DRIVE /ADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	§ 483.25(i) Respirat tracheostomy care The facility must en needs respiratory care and tracheal scare, consistent wit practice, the compressed and 483.65 of this series. This REQUIREMENT by:  Based on observative review, the facility forder for Continuous (CPAP) (delivers on through a mask and four residents (R24). Findings include:  Review of R24's signate Data Set (MDS) dawas admitted on 12 and used a CPAP.  Review of R24's facility for the control of R24's phencified R24 had a sleep apnea (sleep repeatedly stops and Review of R24's phencified R24 had a sleep apnea (sleep repeatedly stops and Review of R24's phencified R24 had a sleep apnea (sleep apnea (sleep apnea settings was lacked a physician's During an observat R24 was observed	and tracheal suctioning. Issure that a resident who lare, including tracheostomy luctioning, is provided such lare person-centered lents' goals and preferences, lubpart. In is not met as evidenced licion, interview, and document lailed to obtain a physician's licins Positive Airway Pressure lare respended air into the airways lare a tube) therapy for one of lare reviewed for respiratory care.  In inficant change Minimum led of 2/28/22, identified R24 lare respiratory care are severed and sever	F 6	i95	F695- D Respiratory/Tracheostomy and Suctioning Facility failed to obtain a physician order for Continuous Positive Airwa Pressure (CPAP) therapy for one reviewed for respiratory care.  1. F695 2. Order for CPAP was obtained a for R24. All other residents with obstructive sleep apnea were review CPAP orders. 3. All residents with sleep apnea was CPAPs are at risk of being affect this deficient practice. 4. Education provided to nursing a related to the importance of having CPAP order in place for a resident requires a CPAP. 5. Audits initiated 4/21/22 to be completed and audited by the DON designee once weekly for four week every other week for one month. At will be reviewed at QAPI for review 6. DON/designee will be responsicompliance. 7. This deficiency will be corrected 5/9/22.	sy esident 3/31/22 wed for who cted by staff a who or ks then udits	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245581	B. WING		1	C
NAME OF F	PROVIDER OR SUPPLIER	240001	1	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	31/2022
FAIR OA	KS NURSING & REHA	AB 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	R24 was observed and the CPAP mac on his overbed tabl During an observat R24 was observed on. During an interview assistant director of was not certain why CPAP and believed off" when R24 retur 3/14/22.  During an observat the ADON revealed observed to be set 9.0-12.0 pressure.  During a follow-up if a.m. the ADON was which had since be included the "home	sitting on the edge of his bed hine was located next to him	F 6	95		
F 880 SS=D	Use dated 08/01/15 CPAP/BiPAP would include approved o and use of humidific supporting diagnos Infection Preventior CFR(s): 483.80(a)( §483.80 Infection CThe facility must estinfection prevention designed to provide	n & Control 1)(2)(4)(e)(f)	F 8	80		5/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		045504	B. WING			C	
NAME OF	200//050 00 01/00//50	245581	D. WING		03/	31/2022	
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  201 SHADY LANE DRIVE  WADENA, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)				(X5) COMPLETION DATE	
F 880	diseases and infector §483.80(a) Infection program. The facility must es and control program a minimum, the following services of the staff, volunteers, visproviding services of the staff, volunteers, the staff, volunteers, visproviding services of the staff, volunteers, or the staff, volunteers, or the staff, volunteers, visproviding the staff, volunteers, visproviding to conducted according accepted in the staff, volunteers, visproviding services of the staff, volunteers, visproviding servic	ansmission of communicable ions.  In prevention and control  tablish an infection prevention in (IPCP) that must include, at owing elements:  Stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual I upon the facility assessmenting to §483.70(e) and following standards;  en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; som possible incidents of ease or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F 8	80			

	ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		(X3) DATE SURVEY COMPLETED		
		245581	B. WING			03/3	3 31/2022
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		201	REET ADDRESS, CITY, STATE, ZIP CODE SHADY LANE DRIVE LDENA, MN 56482	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	(v) The circumstand must prohibit employing disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in the staff involved involve	ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.  Item for recording incidents facility's IPCP and the taken by the facility.  Indle, store, process, and the taken by the facility.  Indle, store, process, and the taken by the spread of the	F8		F880- D Infection Control and Pre Facility failed to ensure PPE was under when providing direct care of three residents who were in droplet precondition, facility failed to ensure resident catheter collection bag wastored in a manner to prevent infection of two reviewed for urinary catholic transportation. The cone of two reviewed for urinary catholic transportation and covered as appropriate with a catholic transportation of the cook deficient between the presence of the surveyor on 3/3 reminding the cook of the appropripe that is to be worn in rooms where the cook of the surveyor on where the cook of the appropripe that is to be worn in rooms where the cook of the surveyor on surveyor or su	sed of five autions. s stion for heters. tion) was eter erbally navior in 30/22, ate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245581	B. WING		03/3	1/2022
	PROVIDER OR SUPPLIER	AB LLC	2	TREET ADDRESS, CITY, STATE, ZIP CODE 101 SHADY LANE DRIVE VADENA, MN 56482	1 00/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	2/10/22, identified I included dementia, renal disease. The severe cognitive imassistance with per dependent for active dressing and bathin Review of R17's nual/27/22, identified I required as needed breath. A later note precautions for upper country and observations for upper country was noted to be eyes were closed, her feet to upper claminated eight (8) which identified R1 precautions, and rewar and gloves was required for er container and a be positioned outside gloves, gowns, two grade masks and container and a be positioned outside gloves, gowns, two grade masks and container and a wear and gloves was and container and a be positioned outside gloves, gowns, two grade masks and container and a wear and contact a placed which identified worn. A four drawe bedside table were	R17 had diagnoses which depression, and end stage MDS identified R17 had apairment, required extensive resonal hygiene and was totally vities of daily living (ADL's) withing.  Irsing progress notes dated R17 had wheezing and dinhalers for shortness of revealed R17 was placed on per respiratory symptoms.  Ition on 3/28/22, at 4:48 p.m. be laying on her back in bed, covered with a blanket from nest. R17's door had a by 11 inch laminated sign 7 was on contact and droplet evealed a mask, gown, eye ere required to enter the room. I sign, identified an N95 mask aftry. A four drawer plastic diside table were also of R17's room, which held a types of N95 masks, medical disinfecting wipes with	F 880	require droplet precautions, including R249. NA-E donned an appropriate mask when he located them in the outside of R17 s door on 3/30/22. was verbally educated on 3/30/22 importance of donning all appropriate PPE prior to entering an isolation residuding R245 s, even if just make bed.  3. Residents and their represental received education on the facility sinfection prevention control program related to them and to the degree possible/consistent with resident scapacity. All residents who require and/or droplet precautions and all residents with catheters could be a by this deficient practice.  4. The QAPI team and/or designed conducted a root cause analysis to identify the problem that resulted in deficiency. The Infection Prevention DON reviewed policies and proced for donning/doffing PPE, during Cowith current guidelines to include of standard of care, contingency standard of care, contingency standard and transmission-based precautions. A residents with catheters were reviewed ensure physician orders and care payed instruction on placement and storage of the catheter collection be and all staff who enter resident and storage of the catheter collection control practices, including but not limited and related to standard infection control practices. including but not limited and storage including but not limited and related to standard infection control practices. including but not limited and storage including but not limited.	e N95 drawer NA-D of the ate oom, ing a atives s m as it s contact ffected ee, n this nist and lures ovid-19 risis dard of nd ks and III ewed to olans ags. are staff rooms	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245581	B. WING			31/2022	
	PROVIDER OR SUPPLIER  KS NURSING & REH	AB LLC	2	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SHADY LANE DRIVE VADENA, MN 56482	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 880	During an observat R17 was noted to be covered with a blue doorway continued contact and droplet an N95 was require plastic container ar positioned outside gloves, gowns, two grade masks and dinstructions of use.  During an observat R17 was noted to be eyes were closed a from her feet to her assistant (NA)-E ar and proceeded to a NA-E had on eye pmask, gloves and a eye protection, an I disposable gown at R17 with morning of the same and proceeded to assist to a tilt in space chawith NA-E. NA-E regrade mask.  - at 8:42 a.m. NA-E gloves, gown, med	s, medical grade masks and with instructions of use.  ion on 3/29/22, at 2:38 p.m. be laying on her back in bed, blanket up to her chin. R17's to have signs, identifying a precautions which identified ed to be worn. A four drawer and a bedside table were also of R17's room, which held a types of N95 masks, medical disinfecting wipes with  ion on 3/30/22, at 8:14 a.m. be laying in bed on her back, and was covered with a blanket or chin. At that time, nursing and NA-C, entered R17's room assist R17 with morning cares. To tection, a medical grade and disposable gown, NA-C wore N95 mask, gloves and a and both proceeded to assist	F 880	transmission-based precautions, appropriate PPE use, and donnin doffing of PPE. Training included competency testing of staff which documented via attestation states completion. Furthermore, educat provided to direct care staff relate overall catheter care, placement, storage.  6. The DON, Infection Prevention and/or designee will conduct real audits of donning/doffing PPE wit transmission-based precautions is shifts four times a week for one withen twice weekly for one week of compliance is met. Real time and also include aerosolized generati procedures and proper use of going ensure PPE is in use. Audits will until 100% compliance is met on control masking for staff, visitors, residents. Audits will be reviewed for review. Catheter care audits in on 5/2/22 to be completed and authe DON or designee three times for four weeks, then weekly for of month. Audits will be reviewed at review.  7. DON/Infection Preventionist/responsible for compliance.  8. This deficiency will be correct 5/2/22.	n was ment of ion was ed to and onist -time th on all week, nce lits will ng wns to continue source and at QAPI nitiated udited by weekly ne QAPI for Designee		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG	СОМ	(X3) DATE SURVEY COMPLETED		
		245581	B. WING			C <b>31/2022</b>	
	PROVIDER OR SUPPLIER  KS NURSING & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482	03/	31/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 880	During an interview stated R17 was on precautions and incomplete protection and was not able to weathere were none aviour drawer plastic room, pulled the se several dozen N95 pull the third drawer another several dozindicated he had not entering R17's room.  During an interview NA-C stated R17 with droplet precautions respiratory symptom was required to be changed to another vaccinated and and leaving R17's room.  During an interview LPN-B confirmed R17's morning indicated had she in did not notice what when R17's morning indicated had she in grade mask on, she education and had.  During an interview facility infection prehad been placed or	on 3/30/22, at 8:43 a.m. NA-E contact and droplet dicated staff were to wear the ering her room; gown, gloves, an N95 mask. NA-E stated he ar an N95 into R17's room, as ailable. NA-E then moved to a container outside of R17's cond drawer open, revealed masks. NA-E proceeded to ropen, which revealed zen N95 masks. NA-E of checked the drawers before in.  on 3/30/22, at 12:37 a.m. as currently on contact and due to a cough and other ins. NA-C indicated an N95 worn in R17's room, and mask, (medical grade if other N95 if unvaccinated) after	F 88				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING		COMPLETED		
		245581	B. WING_			C 31/2022
	PROVIDER OR SUPPLIER	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  201 SHADY LANE DRIVE  WADENA, MN 56482	1 00.	1/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	tested negative for were required to we precaution rooms, a eye protection.  R249  Review of R249's fa health record (EHR admitted to the facion of R249's in EHR identified R24 the recommended of Therefore, R249 was Droplet Precautions.  During an observation R249's room revearead "Contact and I signs indicated staff don (put on) eye progown, and gloves don prior to entering set of drawers outs.  During an observation of drawers outs.  During an observation of drawers outs.  During an observation of drawers outs.  During an interview was done of drawers of drawers outs.  During an interview was done of drawers of drawers outs.	COVID-19. The IP stated staff ear an N95 in contact/droplet along with gowns, gloves, and acce sheet in the electronic ), revealed R249 was lity on 3/24/22.  Immunizations record in the 9 was not up to date with all COVID-19 vaccine doses. as placed on Contact and is upon admission.  Ion 3/29/22, at 11:12 a.m. of led signs on the door which Droplet Precautions." The f entering the room were to obtection, N95 mask, isolation The supplies for the staff to g the room were located in a lide the room.  Ion on 3/29/22, at 10:56 a.m., NA)-D entered R249's room, the bed in the room without	F 88	30		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245581	B. WING			03/		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 201 SHADY LANE DRIVE WADENA, MN 56482	DE	03/	31/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD I	3E	(X5) COMPLETION DATE	
F 880	revealed R245 was 3/25/22.  Review of R245's ir EHR revealed R245 the recommended Therefore, R245 was Droplet Precautions  During an observat R245's room had si "Contact and Droplindicated staff enterprotection, N95 mather supplies for the the room were locating the cook (C)-A was serving R245 a lungown.  During an interview director of nursing (observed C-A in R2 tray without wearing confirmed C-A shout on the contact and Drople Review of the facilities.)	ace sheet in the EHR, admitted to the facility on munizations record in the was not up to date with all COVID-19 vaccine doses. as placed on Contact and supon admission.  Sion on 3/28/22, at 4:45 p.m. igns on the door which read et Precautions." The signs ring the room were to don eye sk, isolation gown, and gloves e staff to don prior to entering ted in a set of drawers outside ion on 3/29/22, at 12:11 p.m., sobserved in R245's room ch tray while not wearing a con 3/29/22, at 12:12 p.m., the (DON) indicated she had a solution gown. The DON and have donned a gown prior room due to the resident being	F8	BEFICIENCY)				
	during [the] COVID- identified upon adm residents who were vaccinations would	-19 Pandemic revised 2/12/22, hission and/or readmission and up to date with COVID-19 be placed on droplet and for a period of 10 days.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		045504	B. WING			С
		245581	B. WING		03/	31/2022
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS NURSING & REHAB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 880	Precautions revised transmission-based when transmission prevented by stand facility was expected door or wall outside indicating the type opersonal protective.  Catheter Care  R30's quarterly Min 3/3/22, identified R3 included dementia, amputations and obidentified R30 had and required extens of daily living (ADL's hygiene and was to The MDS identified catheter.  R30's current physifor a supra pubic catheter.  R30's current physifor a supra pubic catheter.  R30's current physifor a supra pubic catheter is anchore physician orders lact the catheter collection.  R30's current care R30 required a supsignificant urinary reuropathy. The care	ty policy titled Isolation d 6/23/20, identified d precautions would be used could not be reasonably ard precautions alone and the ed to post clear signage on the effect of the resident room of precautions and required equipment (PPE).  Simum Data Set (MDS) dated 30 had diagnoses which bilateral above the knee ostructive uropathy. The MDS severe cognitive impairment sive assistance with activities s) of dressing, personal stally dependent for bathing. R30 had an indwelling urinary diagnoses to the urinary bladder and the urine from the bladder in the urinary bladder and the urine from the bladder in struction of normal urinary every shift, cleanse tubing, d via Velcro or tape. R30's cked direction on placement of	F 8	80		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245581	B. WING			C / <b>31/2022</b>	
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS NURSING & REHAB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482	1 00	10112022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (CEACH CORRECTIVE ACTION SHOUTH CORREST TO THE APPROPRIES OF THE PROVIDENCY)	ULD BE	(X5) COMPLETION DATE	
F 880	R30 was noted to bed, his eyes were with a blanket from mid chest. R30's cafrom underneath the bed, and lead to a codirectly on a fall material and a fall material an	ion on 3/28/22, at 5:18 p.m. e laying on his back in low closed and he was covered his lower extremities to his atheter tubing was observed e blanket on the left side of his collection bag which laid ton the floor.  was observed to remain laying n a low bed (bed that is able bund level), his eyes were covered with a blanket. R30's bag remained laying directly floor.  ion on 3/29/22, at 10:51 a.m. the laying in bed on his back, in wes were closed, he was ket up to the top of his chest. Section bag was observed de of his bed, directly on a fall sion on 3/30/22, at 7:34 a.m. the laying in bed on his back, in we laying in bed on his back, in the left side of his bed, fall mat on the floor.  was observed laying on his his eyes were closed and he blanket from his legs to his er collection bag, half full of observed laying directly on a	F 8	80			

AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	) MULTIPLE CONSTRUCTION BUILDING		COMPLETED	
		245581	B. WING		0:	C 3/31/2022	
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS NURSING & REHAB LLC				STREET ADDRESS, CITY, STATE, ZIP COD 201 SHADY LANE DRIVE WADENA, MN 56482		310 11/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 880	back in a low bed, I catheter collection I the floor on the left observed in the bag mat on the floor.  During an interview stated R30 was total which included dress bathing. NA-E indicated received catheter of the collection bag with bladder, on the grow wheelchair. NA-E with for R30's catheter of the collection I mat on R30's floor. R30's room, and to LPN-A opened the plastic catheter bag catheter collection I black bag and place left side of R30's be brought the catheter few days ago. She prevented the catheter completely off the first side of the first side of the catheter completely off the first side of the first side of the catheter completely off the first side of the first side of the catheter completely off the first side of the catheter cat	on 3/30/22, at 2:23 p.m. NA-Eally dependent for all ADL's, ssing, personal hygiene and ated R30 had a catheter, ares twice daily and indicated was to be placed below R30's was unaware of any cover used		380			
	infection prevention expect resident cat placed in a cover a possible. IP stated	on 3/31/22, at 8:46 a.m. the list (IP) stated she would heter collection bags to be nd kept off the floor if at all R30 had a low bed, which eter from being off the floor,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245581	B WING				04/0000
NAME OF F	PROVIDER OR SUPPLIER	240001	]	STREET ADDRESS, CITY, STA	TE, ZIP CODE	03/-	31/2022
FAIR OAKS NURSING & REHAB LLC				201 SHADY LANE DRIVE			
TAIR OA				WADENA, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIV CROSS-REFERENCEI		BE	(X5) COMPLETION DATE
F 880	· ·	_	F 8	30			
		eted the collection bag to be e possible infection control					
	A facility policy titled Management, revis bags would be cove	ed 11/4/20, identified catheter					



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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED		
		00670	B. WING			C <b>03/31/2022</b>	
NAME OF I	PROVIDER OR SUPPLIER	00679		CTATE ZID CODE	03/3	51/2022	
		201 SHΔΓ	DY LANE DR	STATE, ZIP CODE I <b>VE</b>			
FAIR OA	KS NURSING & REHA	AB LLC WADENA	, MN 56482				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall I	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.					
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of I lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag le number indicated below. It is several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was					
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	conducted at your faminnesota Departm facility was found N State Licensure and orders are issued. F	FS: /22, a licensing survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN d the following correction Please indicate in your orrection you have reviewed					

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

(X6) DATE TITLE Electronically Signed 04/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:	A. BUILDING:		С	
		00679	B. WING			31/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
FAIR O	AKS NURSING & REH	ABIIC	OY LANE DR J., MN 56482	IVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 000	Continued From pa	nge 1	2 000				
	these orders and id be completed.	lentify the date when they will					
	the State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far letter ag." The state statisted in the "Summe column and replace the correction order the findings which a statute after the state as evidence by." For are the Suggested Time period for Control You have agreed to receipt of State lice the Minnesota Depunformational Bulleth Minnesota Depunformational Bulleth Minnesota Depunformational Bulleth the Minnesota Depunformational Bulleth the Minnesota Depunformational Bulleth the Minnesota Depunformation orders are delineated Department of Heavyou electronically, is necessary for State necessary for State licensure procompletion date, the corrected prior to employed Minnesota Department PLEASE DISREGATE FOURTH COLUMN "PROVIDER'S PLASE DISREGATED TO THE COLUMN" "PROVIDER'S PLASE DISREGATED TO THE COLUMN "PROVIDER" TO THE COLUMN "PR	o participate in the electronic ensure orders consistent with artment of Health tin state.mn.us/facilities/regulatio_1.html The State licensing ed on the attached Minnesota lith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.					

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 2 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00679	B. WING		C 03/31/2022		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/0	7172022	
FAIR OA	KS NURSING & REHA	AB LLC	Y LANE DR , MN 56482	IVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	IS NO REQUIREM CORRECTION FO	R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES.					
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			5/9/22	
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,					
	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.			No POC required.			
	2/10/22, identified Fincluded dementia, renal disease. The severe cognitive im assistance with per dependent for activ dressing and bathir had no rejection of look back period.	imum Data Set (MDS) dated R17 had diagnoses which depression, and end stage MDS identified R17 had pairment, required extensive sonal hygiene and was totally ities of daily living (ADL's) of ng. The MDS revealed R17 cares during the seven day					

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 3 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00679	B. WING		03/3	31/2022
	PROVIDER OR SUPPLIER	ABILC 201 SHAD	DRESS, CITY, S DY LANE DRI , MN 56482	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 920	had an ADL deficit, dressing, bathing at care plan directed f and to attempt to tri necessary and pref care plan lacked directed facial hair removal.  On 3/28/22, at 4:48 laying on her back is covered with a blan chest. R17 had sev (5) to seven (7) mill wispy chin hairs and three (3) mm long, her chin, upper lip at the covered with a blan chest. R17 had sev (5) to seven (7) mill wispy chin hairs and three (3) mm long, her chin, upper lip at cover the bed, rolling R17 continued to has 5-7 mm long, white dozen 2-3 mm long along her chin, upper mouth. R17's hands her fingernails were length, were jagged nail polish and were brownish substance ten of her fingernail.  - at 2:38 p.m. during laying on her back is blanket up to her chin covers of approxim wispy chin hairs and thick, black, course	required assistance with and personal hygiene. R17's acility staff to check nail length im and clean on bath day, as erred to have long nails. R17's rection and preferences for  p.m. R17 was observed in bed, eyes were closed, ket from her feet to upper eral dozen, approximately five imeters (mm) long, white, diseveral dozen, two (2) to thick, course black hair along and corners of her mouth.  a.m. R17 was observed ace wheelchair (specialized cioning) in her room with her aced the doorway, she had an grable placed in front of her. ave dozens of approximately, wispy chin hairs and several, thick, black, course hairs er lip and corners of her is rested on her lap, all ten of approximately 2-3 mm of lit, had chipped mauve colored to observed to have a thick a underneath the length of all	2 920			

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 4 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BOILDING.			c	
	00679	B. WING			31/2022	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FAIR OAKS NURSING & REHA	ABIIC	OY LANE DRI , MN 56482	VE			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
approximately 2-3 r had chipped mauve observed to have a underneath the length of all ten closed and was confeet to her chin. At a (NA)-E and NA-C, of proceeded to assist was assisted from I wheelchair, NA-E p R17 continued to has 5-7 mm long, white dozen 2-3 mm long along her chin, upp mouth. R17's finger and had a thick broathe length of all ten com with an over t R17 continued to has 5-7 mm long, white dozen 2-3 mm long, white dozen 2-3 mm long along her chin, upp mouth. R17's finger and had a thick broathe length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face thave dozens of app white, wispy chin has long, thick, black, cat a side of the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face thave dozens of app white, wispy chin has long, thick, black, cat a side of the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face thave dozens of app white, wispy chin has long, thick, black, cat a side of the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face thave dozens of app white, wispy chin has long, thick, black, cat a side of the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face that the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face that the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face that the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face that the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face that the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face the length of all ten cat 11:51 a.m. during seated in a tilt in sp positioned to face t	f her fingernails were mm of length, were jagged, e colored nail polish and were thick brownish substance gth of all ten of her fingernails.  a.m. during an observation, sed on her back, eyes were vered with a blanket from her that time, nursing assistant entered R17's room and tr R17 with morning cares. R17 her bed to a tilt in space roceeded to brush R17's hair. ave dozens of approximately, wispy chin hairs and several ser lip and corners of her mails continued to be jagged, whish substance underneath fingernails.  If an observation, R17 a tilt in space chair in her he bed table in front of her. ave dozens of approximately, wispy chin hairs and several stilt in space chair in her he bed table in front of her. ave dozens of approximately, wispy chin hairs and several stilt, thick, black, course hairs er lip and corners of her mails continued to be jagged, whish substance underneath	2 920				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 5 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00679	B. WING			31/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	ABIIC	DY LANE DRI	VE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	, <b>MN 56482</b>	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 920	Continued From pa	ge 5	2 920			
	fingernails continue thick brownish subs of all ten fingernails On 3/30/22, at 8:43 NA-E indicated R17 ADL's, which include and bathing. NA-E was able to verbaliz staff were to anticipe did not offer to remone attempt to provine was not aware of facial hair removal responsible for R17 On 3/30/22, at 12:3 NA-C stated R17 wher ADL's of dressin and all mobility. NA	d to be jagged, and had a stance underneath the length.  a.m. during an interview, was totally dependent for all ed dressing, personal hygiene indicated he did not feel R17 te her needs or wishes and ate her needs. NA-E stated he ove R17's facial hair and did de nail care. NA-E indicated f R17's preferences regarding and was not sure who was "s nail care.  7 p.m. during an interview, as totally dependent for all of ng, bathing, personal hygiene-C confirmed R17 was not				
	offered to have her morning cares and NA-C indicated R17 on her bath day and NA-C stated she was substance was undindicated she was r substance had bee fingernails.  On 3/30/22, at 12:5 licensed practical in had dozens of 5-7 in hairs and several diblack, course hairs corners of her mour R17's fingernails we brownish substance ten fingernails. LPN	facial hair removed during had not been offered since. 7's nail were cleaned and filed d as needed by other staff. as not sure what the brown erneath R17's nails and not sure how long the				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 6 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00679	B. WING			C <b>31/2022</b>
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE		0 11 20 22
FAIR OA	KS NURSING & REHA	ABIIC	DY LANE DR	IVE		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	N, MN 56482	PROVIDER'S PLAN OF CORE	RECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 6	2 920			
	indicated R17 used appearance prior to On 3/31/22, at 8:37 assistant director of felt R17 did not like fingernails, preferred difficult to keep her ADON stated she fel have her facial hair	nted and filed. LPN-B to take pride in her her dementia diagnosis.  a.m. during an interview the f nursing (ADON) stated she anyone to touch her d them long and felt it was nails well manicured. The elt R17 likely had refused to removed, indicated the facility				
	cares such as nail of other grooming and how to document restated she would expend the state of	en assisting with resident care, facial hair removal and I felt they were not aware of esident refusals. The ADON expect R17 to be offered to be her nail care provided as				
	interview, R17's fan prior to R17's deme pride in her overall manicured fingerna spoken to facility st concerns with R17's appearance. FM-A	a.m. during a telephone nily member (FM)-A stated entia diagnosis, she had taken appearance and had well ils. FM-A indicated he had aff in the past year about a facial hair, nails and overall stated he expected R17 be her facial hair and be well basis.				
	activity director (AD offered nail care an 3/28/22, and had re was unaware if R17 with shaving or nail her refusal. AD-A st	a.m. during an interview, b)-A stated R17 had been d shaving on Monday, fused. AD-A indicated she had been offered assistance care on any days following tated R17 had been assisted ng interview with nursing staff				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 7 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING		C		
	00679	B. WING		03/3	1/2022	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FAIR OAKS NURSING & REHA	ABIIC	OY LANE DR , MN 56482	VE			
PREFIX (EACH DEFICIENC)	PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETE DATE	
3/3/22, identified R3 included dementia, the knee amputation had severe cognitive extensive assistance (ADL's) of dressing totally dependent for R30 had no rejection assessment period.  R30's care plan reverse had an ADL self care with dressing, bathing care plan did not indicate plan did not indicate plan did not indicate plan did not have a would shave his fact R30 liked to have a would shave his fact R30 had a mustace did not have a bear shaven. FM-B indicate R30's wife had voice appearance. She in unkept, he was unsuppearance. FM-B nursing and had no concerns regarding.  On 3/28/22, at 5:18 laying in bed on his was covered with a extremities up to his was covered with the stubble approximate.	imum Data Set (MDS) dated 30 had diagnoses which anxiety and bilateral above ns. The MDS identified R30 re impairment and required se with activities of daily living personal hygiene and was or bathing. The MDS identified on of cares during the rised 3/24/22, revealed R30 re deficit, required assistance ng, and personal hygiene. The entify R30's facial hair or	2 920				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 8 of 23

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  201 SHADY LANE DRIVE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
FAIR OAKS NURSING & REHABILIC 201 SHADY LANE DRIVE			00679	B. WING			_
FAIR OAKS NURSING & REHAB LLC	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WADENA, MN 56482	FAIR OA	AKS NURSING & REH	ABIIC		VE		
	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
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.  - 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	neck and upper lip.  On 3/29/22, at 10:5 laying in bed on his closed and was covered white per lip.  -at 3:46 p.m. R30 white per lip.  -at 4:44 a.m. R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to her lip.  -at 11:44 a.m. R30 in space chair	and an				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 9 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00679	B. WING		03/3	C 8 <b>1/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA	ABILC 201 SHAD	DRESS, CITY, S DY LANE DR , MN 56482	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 920	which included dres bathing. NA-E indic weekly and he had couple of days.  On 3/30/22, at 2:40 (LPN)-A confirmed appeared R30 had days. LPN-A indicates shaven and should  On 3/31/22, at 8:46 stated she felt R30 routinely refused caindicated R30 histo with staff and could She indicated she vidocumenting R30's staff to document a  On 3/31/22, at 9:30 (AD)-A stated R30 vistaff to document and refacility policy titled (ADL's) revised 3/1 assessment and refacility must provide services. The policy provide the followin	ssing, personal hygiene and ated R30 was shaved twice not shaved R30 in the past p.m. licensed practical nurse R30's facial hair, indicated it not been shaved for a few ted R30 preferred to be clean have been shaved daily.  p.m. the facility administrator had refused shaving and ares. The administrator rically was verbally aggressive be very difficult to work with. was not aware if staff were refusals, though would expect	2 920			
	director of nursing ( review and revise p	HOD OF CORRECTION: The DON) or designee could olicies and procedures related living. The director of pursing				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 10 of 23

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00670	B. WING		C <b>03/31/2022</b>	
		00679			03/3	31/2022
	PROVIDER OR SUPPLIER	201 SHAD	Y LANE DR	STATE, ZIP CODE IVE		
FAIR OA	KS NURSING & REHA	AB LLC	MN 56482	··-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 10	2 920			
	staff and develop a staff are providing a daily living.	develop a system to educate monitoring system to ensure assistance with activities of R CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			5/9/22
	control program mu procedures which pare collection to identify residents;  B. a system for control of outbreaks.  C. isolation and reduce risk of trans.  D. in-service exprevention and con.  E. a resident he immunization progration of the procedures of resident the procedures of resident the prevention and formulation. F. the development of the procedures of the procedures of resident of the procedures of the procedures of resident of the procedures of the	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of policies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and				

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00679			03/3	1/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/3	112022
		201 SHAD	Y LANE DR	•		
FAIR OA	KS NURSING & REHA	AB LLC	MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21390	Continued From page 11		21390			
	by: Based on observati review, the facility for protective equipme providing direct care R245 and R249) wh In addition, the facil catheter collection is	ent is not met as evidenced on, interview and document ailed to ensure personal nt (PPE) was used when e for 3 of 5 residents (R17, no were in droplet precautions. ity failed to ensure resident oag was stored in a manner to r 1 of 2 residents (R30) y catheters.		No POC required.		
	Findings include:					
	Transmission Base	d Precautions				
	R17					
	2/10/22, identified F included dementia, renal disease. The severe cognitive im assistance with per	imum Data Set (MDS) dated R17 had diagnoses which depression, and end stage MDS identified R17 had pairment, required extensive sonal hygiene and was totally ities of daily living (ADL's) with ng.				
	3/27/22, identified F required as needed breath. A later note	rsing progress notes dated R17 had wheezing and inhalers for shortness of revealed R17 was placed on er respiratory symptoms.				
	R17 was noted to be eyes were closed, of her feet to upper chaminated eight (8)	ion on 3/28/22, at 4:48 p.m. e laying on her back in bed, covered with a blanket from lest. R17's door had a by 11 inch laminated sign 7 was on contact and droplet				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 12 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00679	B. WING		03/3	31/2022
	PROVIDER OR SUPPLIER	ABILC 201 SHAD	DRESS, CITY, S DY LANE DR , MN 56482	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	precautions, and re wear and gloves we A further laminated was required for en container and a bed positioned outside of gloves, gowns, two grade masks and dinstructions of use.  During an observation R17 was seated in the room, had a we throat she was unaing room had contact a placed which identification worn. A four drawer bedside table were R17's room, which it types of N95 masks disinfecting wipes with the covered with a blue doorway continued contact and droplet an N95 was required plastic container and positioned outside of gloves, gowns, two grade masks and dinstructions of use.	vealed a mask, gown, eye ere required to enter the room. sign, identified an N95 mask try. A four drawer plastic did table were also of R17's room, which held a types of N95 masks, medical isinfecting wipes with  son on 3/29/22, at 10:21 a.m. a tilt in space wheelchair in to cough and congestion in her tole to clear. R17's door to her and droplet precautions signs fied an N95 was required to be plastic container and a also positioned outside of held a gloves, gowns, two s, medical grade masks and with instructions of use.  son on 3/29/22, at 2:38 p.m. to have signs, identifying precautions which identified to be worn. A four drawer d a bedside table were also of R17's room, which held a types of N95 masks, medical isinfecting wipes with	21390			
	R17 was noted to b eyes were closed a from her feet to her assistant (NA)-E an	ion on 3/30/22, at 8:14 a.m. e laying in bed on her back, nd was covered with a blanket chin. At that time, nursing d NA-C, entered R17's room ssist R17 with morning cares				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 13 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00679	B. WING			C <b>31/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	ABIIC	Y LANE DRI , MN 56482	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21390	NA-E had on eye promask, gloves and a eye protection, an Natisposable gown ar R17 with morning of at 8:38 a.m. licens entered R17's room N95 mask, gloves a proceeded to assist to a tilt in space chawith NA-E. NA-E regrade mask.  - at 8:42 a.m. NA-E regrade mask.  - at 8:42 a.m. NA-E gloves, gown, medith hand hygiene and of mask.  During an interview stated R17 was on precautions and incomplete for and was not able to weathere were none average for a several dozen N95 pull the third drawer another N95 pull the third drawer another N95 pull the N95 pull	rotection, a medical grade a disposable gown, NA-C wore N95 mask, gloves and a nd both proceeded to assist eares.  ed practical nurse (LPN)-C n, she wore eye protection, an and a disposable gown and transfer from her bed ear with a full mechanical lift mained wearing a medical area medical grade mask, completed donned a new medical grade on 3/30/22, at 8:43 a.m. NA-E contact and droplet dicated staff were to wear the earing her room; gown, gloves, an N95 mask. NA-E stated he ar an N95 into R17's room, as aliable. NA-E then moved to a container outside of R17's cond drawer open, revealed masks. NA-E proceeded to ropen, which revealed zen N95 masks. NA-E ot checked the drawers before	21390			

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 14 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00679	B. WING		03/3	; 1/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/0	172022
	KS NURSING & REHA	ABIIC 201 SHAD	Y LANE DR	·		
	CLIMANA DV CTA		MN 56482	DDOV/DEDIC DLAN OF CODDECT	ONI	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From page 14		21390			
	vaccinated and another N95 if unvaccinated) after leaving R17's room.					
	LPN-B confirmed R precautions and state N95 mask when in did not notice what when R17's mornin indicated had she regrade mask on, she education and had During an interview facility infection prehad been placed or precautions due to tested negative for were required to we	on 3/30/22, at 1:05 p.m. R17 was on contact and droplet aff were required to wear an her room. LPN-B stated she type of mask NA-E had on ag cares were provided. She noticed NA-E had a medical e would have provided him to change to an N95.  on 3/31/22, at 8:37 a.m. the ventionist (IP) confirmed R17 in contact and droplet respiratory symptoms and had COVID-19. The IP stated staff ear an N95 in contact/droplet along with gowns, gloves, and				
	R249					
		ace sheet in the electronic d), revealed R249 was lity on 3/24/22.				
	EHR identified R24 the recommended	mmunizations record in the 9 was not up to date with all COVID-19 vaccine doses. as placed on Contact and s upon admission.				
	R249's room revea read "Contact and I signs indicated staf don (put on) eye pr	ion 3/29/22, at 11:12 a.m. of led signs on the door which Droplet Precautions." The if entering the room were to otection, N95 mask, isolation The supplies for the staff to				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 15 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED	
			B. WING			С
		00679	B. WING		03/3	31/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	ABIIC	DY LANE DR A, MN 56482	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 15	21390			
	don prior to entering set of drawers outs	g the room were located in a ide the room.				
	nursing assistant (N	ion on 3/29/22, at 10:56 a.m., NA)-D entered R249's room, the bed in the room without a gown.				
	NA-D verbalized sh gown when entering	on 3/29/22, at 10:56 a.m., he should have been wearing a g the room and confirmed she n when she was in R249's				
	R245					
		ace sheet in the EHR, admitted to the facility on				
	EHR revealed R245 the recommended 6	mmunizations record in the 5 was not up to date with all COVID-19 vaccine doses. as placed on Contact and s upon admission.				
	R245's room had si "Contact and Drople indicated staff enter protection, N95 mas The supplies for the	ion on 3/28/22, at 4:45 p.m. igns on the door which read et Precautions." The signs ring the room were to don eye sk, isolation gown, and gloves. e staff to don prior to entering ted in a set of drawers outside				
	the Cook (C)-A was	ion on 3/29/22, at 12:11 p.m., s observed in R245's room ch tray while not wearing a				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 16 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00070	B. WING		00/0	
		00679	B. WING		03/3	1/2022
	PROVIDER OR SUPPLIER	201 SHAF	DRESS, CITY, S	STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	ABIIC	, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	During an interview director of nursing (observed C-A in R2 tray without wearing confirmed C-A shout to entering R245's non Contact and Drown Review of the facilit Transfers, and return during [the] COVID-identified upon admiresidents who were vaccinations would contact precautions. Review of the facilit Precautions revised transmission-based when transmission prevented by standardility was expected door or wall outside.	on 3/29/22, at 12:12 p.m., the (DON) indicated she had (45's room serving the lunch gan isolation gown. The DON (14) and isolation gown. The DON (15) and isolation gown. The DON (16) are room due to the resident being oplet isolation.  By policy titled Admission, rn from Outings for Residents (19) and (19) are readmission and/or readmission and (19) are readmission and the deposit clear signage on the resident room of precautions and required	21390			
	Catheter Care					
	3/3/22, identified R3 included dementia, amputations and obidentified R30 had sand required extens of daily living (ADL's hygiene and was to The MDS identified catheter.	imum Data Set (MDS) dated 30 had diagnoses which bilateral above the knee ostructive uropathy. The MDS severe cognitive impairment sive assistance with activities s) of dressing, personal tally dependent for bathing. R30 had an indwelling urinary				
	R30's current physi	cian orders revealed an order	1		l	

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 17 of 23

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00679	B. WING		03/3	; 1/2022
	PROVIDER OR SUPPLIER	ABILC 201 SHAD	DRESS, CITY, S DY LANE DR , MN 56482	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	for a supra pubic car connection between skin used to drain used to drain used to drain used to drain used to be flow), catheter care catheter is anchored physician orders late the catheter collect.  R30's current care R30 required a supsignificant urinary ruropathy. The care placement of R17's During an observat R30 was noted to be bed, his eyes were with a blanket from mid chest. R30's cafrom underneath the bed, and lead to a directly on a fall material at 6:49 p.m. R30's in bed on his back to be lowered to gracely on a fall material at 6:49 p.m. R30's in bed on his back to be lowered to gracely on a fall material at 6:49 p.m. R30's catheter collection on a fall mat on the During an observat R30 was noted to be a low bed. R30's excepted with a blank R30's catheter collection on the left signat on the floor.	atheter (surgically created in the urinary bladder and the urine from the bladder in struction of normal urinary every shift, cleanse tubing, divia Velcro or tape. R30's cked direction on placement of ion bag.  plan revised 3/24/22, revealed ra pubic catheter due to estention and obstructive plan lacked instructions for a catheter collection bag.  ion on 3/28/22, at 5:18 p.m. is laying on his back in low closed and he was covered his lower extremities to his atheter tubing was observed to blanket on the left side of his collection bag which laid it on the floor.  was observed to remain laying in a low bed (bed that is able bund level), his eyes were covered with a blanket. R30's bag remained laying directly	21390			

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 18 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00679	B. WING		03/3	31/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	ARILC 201 SHAD	Y LANE DR	IVE		
TAIN OA	INS NONSING & INCHIA	WADENA	, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 18	21390			
	R30 was noted to be a low bed. R30's carobserved hanging of laying directly on a second with a chest. R30's cathet yellow urine, was covered with a chest. R30's cathet yellow urine, was of fall mat on the floor at 2:22 p.m. R30 verback in a low bed, it catheter collection is the floor on the left.	e laying in bed on his back, in theter collection bag was off the left side of his bed, fall mat on the floor.  was observed laying on his his eyes were closed and he blanket from his legs to his er collection bag, half full of observed laying directly on a his eyes were opened. R30's bag was observed laying on side of his bed, no urine was				
	mat on the floor.  During an interview stated R30 was tota which included dres bathing. NA-E indic received catheter of the collection bag wheelchair. NA-E w for R30's catheter of During an interview	on 3/30/22, at 2:23 p.m. NA-Eally dependent for all ADL's, using, personal hygiene and ated R30 had a catheter, ares twice daily and indicated as to be placed below R30's und or underneath R30's as unaware of any cover used collection bag.  on 3/30/22, at 2:40 p.m. urse (LPN)-A confirmed R30's				
	catheter collection I mat on R30's floor. R30's room, and to LPN-A opened the plastic catheter bag catheter collection I black bag and place left side of R30's be	bag was laying directly on a fall LPN- walked over to a chair in ok hold of a black plastic bag. bag which revealed a black holder, she then took R30's bag and placed it into the ed the catheter back on the ed. LPN-A stated she had r bag cover into R30's room a				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 19 of 23

STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00679	B. WING		C 03/31/2022	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 33/3	172022
FAIR OA	KS NURSING & REHA	AB LLC	Y LANE DR MN 56482	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From page 19		21390			
	prevented the cathe completely off the f	indicated R30's low bed eter collection bag from being loor, however the cover was th infection control and for				
	infection prevention expect resident cat placed in a cover a possible. IP stated prevented the cathe however she expect	on 3/31/22, at 8:46 a.m. the hist (IP) stated she would heter collection bags to be nd kept off the floor if at all R30 had a low bed, which eter from being off the floor, sted the collection bag to be e possible infection control				
	A facility policy titled Management, revis bags would be cove	ed 11/4/20, identified catheter				
	director of nursing ( review and revise p to ensuring transmi followed. The direct could develop a syst develop a monitoring following guidance	THOD OF CORRECTION: The (DON) and/or designee could olicies and procedures related ssion based precautions were tor of nursing or designee stem to educate staff and ag system to ensure staff are with personal protection ntified transmission based				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one-				
21925	MN St. Statute 144 Residents of HC Fa	.651 Subd. 29 Patients & ac.Bill of Rights	21925			5/9/22
		ers and discharges. Residents ily transferred or discharged.				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 20 of 23

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00679	B. WING		03/3	5 1/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 03/3	1/2022
		201 SHAD	Y LANE DR			
FAIR U	AKS NURSING & REH	WADENA,	MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21925	Residents must be proposed discharge justification no later discharge from the transfer to another notice shall include the proposed action telephone number of ombudsman pursual Act, section 307(a) of this right, may chnotice period ends. shortened in situatic control, such as a creview, the accommesidents, a change treatment program, resident's welfare, prohibited by the pupaying for the resident medical record. This MN Requirement by:  Based on interview to notify the State of facility transfer for creviewed for transfer.  Findings include:  Review of the R8's revealed R8 was ac 7/23/21, and readment readments and readments.	notified, in writing, of the error transfer and its than 30 days before facility and seven days before room within the facility. This the resident's right to contest in, with the address and of the area nursing home and to the Older Americans (12). The resident, informed mose to relocate before the The notice period may be one outside the facility's determination by utilization modation of newly-admitted in the resident's medical or the resident's own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a caccommodate new residents from assignments.  The notice period may be one of two resident's medical or the resident's medical or the resident's own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a caccommodate new residents own assignments.  The notice period may be one of two residents of a caccommodate of the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a caccommodate new residents own assignments.  The notice period may be one of the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a caccommodate new residents own assignments.  The notice period may be one of the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities on a caccommodate new residents own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facility's determination of newly-admitted in the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in facility's determination of newly-admitted in the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in facility's determination of newly-admitted in the residen	21925	No POC required.		

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 21 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00679	B. WING			C <b>31/2022</b>
	PROVIDER OR SUPPLIER	201 SHAI	DRESS, CITY, S	STATE, ZIP CODE	-	
FAIR OA	KS NURSING & REHA	ABIIC	, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21925	Continued From pa	ge 21	21925			
	emergency room di	y and transported R8 to the ue to R8's altered cognition. m. R8 had been re-admitted to				
	month of January a no documentation t	udsman notifications for the nd February 2022, revealed he Ombudsman had been transfer to the hospital.				
	Social Service Directly process for notificate fax, at the beginning residents transferre facility during the process of the notific January 2022, and	on 3/30/22, at 3:10 p.m., the ctor (SSD) indicated the tion of the Ombudsman was to g of the month, a list of ed or discharged from the revious month. SSD confirmed ations for the month of February 2022, revealed the een notified that R8 was ospital.				
	Minimum Data Set R8 was discharged	on 3/30/22, at 3:15 p.m., the (MDS) Coordinator confirmed from the facility on 1/30/22, at ned to the facility the next day, p.m.				
	administrator stated were to fax the Omi discharged on a mo resident had only be administrator confir	on 3/30/22, at 3:20 p.m., the difference that the expectation was staff budsman the list of residents on the part of the een gone for one day. The med the notification of the 1/30/22, had not been no Ombudsman.				
	Readmission, Bed I dated 1/04/19, reve	ry policy titled Admission, Hold, and Transfer/Discharge aled a copy of the [discharge] to a representative of the				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 22 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.110 1 27.11	or connection	BERTH 19/11/16/11/16/BE	A. BUILDING:	A. BUILDING:			
		00679	B. WING		03/3	) 1/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FAIR OA	KS NURSING & REHA	ARTIC	Y LANE DR MN 56482	IVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21925	Continued From pa	ge 22	21925				
	Office of the State I	_ong-Term Care Ombudsman.					
	Director of Social S develop, review, an procedures to ensu notification of all ho The Director of Social educate all appropriocedures.  The Director of Social educate of Social educate all appropriate of Social educate of Social education of Soc	THOD OF CORRECTION: The ervices or designee could d/or revise policies and the ombudsman received spitalizations. Sial Services or designee could diate staff on the policies and sial Services or designee could systems to ensure ongoing R CORRECTION: Twenty-one					

Minnesota Department of Health

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

F5581031

(X2) MULTIPLE CONSTRUCTION

Printed: 04/15/2022 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 01 - DINING ADDITION 01		COMPLETED			
		245581		B. WING		03/2	03/29/2022	
	PROVIDER OR SUPPLIER LKS NURSING & RE	HAB LLC	201 SH	ADDRESS, CITY, STATE, ZIP CODE SHADY LANE DRIVE DENA, MN 56482				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 000	conducted by the M Public Safety, State 03/29/2022. At the Nursing & Rehab-B compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) 101, Life Safe Existing Health Car NFPA 99, the Health Fair Oaks Nursing four different times dining building 02 with 1965 building a was determined to construction. It is safe walkway and a 2-ho	ty recertification survalinnesota Department Fire Marshal Division time of this survey, Filled 01 was found in the requirements for paid at 42 CFR, Subpart from Fire, and the Fire Protection Associately Code (LSC), Clare and the 2012 edition has a Constructed to the constructed by a 10-food our fire barrier. No skullding. The original to	art of on on Fair Oaks articipation art e 2012 siation napter 19 on of de.  ucted at and e west of on that t enclosed eeping	K 000	DEFICIENCY)			
LABORATO	(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			NATURE	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.

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

Printed: 04/15/2022 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - DINING ADDITION 01 COMPLETED 245581 B. WING \_ 03/29/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

FAIR OAKS NURSING & REHAB LLC  WADENA, MN 56482						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)		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	K 000				
K 000	Continued From page 1 system, in all areas open to the corridor, is common areas, and in all sleeping rooms on the facility's fire alarm system that has automatic fire department notification.  The facility has a capacity of 75 beds and census of 42 at the time of the survey.  The requirement at 42 CFR, Subpart 483 is MET.	in all that are	DEFICIENCY			
				n sheet Page 2		

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

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

F5581031

(X2) MULTIPLE CONSTRUCTION

Printed: 04/15/2022 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING	02 - MAIN BUILDING 02	COMPL	COMPLETED	
		245581		B. WING		03/2	29/2022	
FAIR OAKS NURSING & REHAB LLC 201 SH		201 SH	RESS, CITY, S ADY LANE IA, MN 564		•			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 000	conducted by the M Public Safety, State 03/29/2022. At the Nursing & Rehab-B compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe Existing Health Car NFPA 99, the Health Fair Oaks Nursing a four different times dining building 02 withe 1965 building at was determined to construction. It is safe walkway and a 2-ho	ty recertification survalinnesota Department Fire Marshal Division time of this survey, Foldg 02 was found in exequirements for paid at 42 CFR, Subparty from Fire, and the Fire Protection Associately Code (LSC), Clay and the 2012 edition to Care Facilities Code (Rehab was constructed to the condition of the constructed to the code is a 2-story addition of the constructed to the code is a 2-story addition of the	art of on on Fair Oaks articipation art e 2012 ciation hapter 19 on of de.  ucted at and e west of on that t enclosed eeping	K 000	DEFICIENCY)			
LABORATO	determined to be of and has a wood roo 101 Sec 19.1.6.2. It constructed to the eis a 3-story building determined to be of and has a wood roo 101 Sec 19.1.6.2. It constructed to the side of Type II(222) constructed as two building determined to be of Type II(222) constructed to the side of Type II(222) constructed as two buildings and the facility is compared by pipe system and the side of Type system system and the side of Type system syst	letely sprinkler prote and a wet pipe syster detection in the corric	uction, NFPA ition was uilding that and was ruction NFPA dition was mined to illity was cted with m. The dor	NATURE	TITLE		(XG) 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.

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

Printed: 04/15/2022 FORM APPROVED OMB NO. 0938-0391

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

STREET ADDRESS, CITY, STATE, ZIP CODE

FAIR OAKS NURSING & REHAB LLC  WADENA, MN 56482						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)		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	K 000				
K 000	Continued From page 1 system, in all areas open to the corridor, is common areas, and in all sleeping rooms on the facility's fire alarm system that has automatic fire department notification.  The facility has a capacity of 75 beds and census of 42 at the time of the survey.  The requirement at 42 CFR, Subpart 483 is MET.	in all that are	DEFICIENCY			
				n sheet Page 2		



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



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: 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



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: 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 <a href="mailto:Tamika.Brown@cms.hhs.gov">Tamika.Brown@cms.hhs.gov</a>.

#### 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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc">https://mdhprovidercontent.web.health.state.mn.us/ltc</a> 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

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

PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED		
		045504					0
		245581	B. WING			03/	31/2022
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	000			
	with Appendix Z, Er Requirements, §48	1/22, a survey for compliance mergency Preparedness 3.73(b)(6) was conducted ecertification survey. The bliance.					
F 000	signature is not req page of the CMS-29 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.	F 0	000			
	survey was conductinvestigation was alwas found to be Norequirements of 42	1/22, a standard recertification ted at your facility. A complaint lso conducted. Your facility OT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.					
	UNSUBSTANTIATE	810 and MN80869),					
	as your allegation of Departments acception enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required the first page of the CMS-2567 ic submission of the POC will tion of compliance.					
MD05:70-7	onsite revisit of you validate that substa regulations has bee	acceptable electronic POC, an r facility may be conducted to intial compliance with the en attained.	IATURE.		TITLE		(VC) DATE
LABORATOR\	Y DIRECTOR'S OR PROVID	JEK/SUPPLIER REPRESENTATIVE'S SIGN	MAIURE		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:	` '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		045504				С	
		245581	B. WING		03	/31/2022	
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 623 SS=D	CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility trar resident, the facility (i) Notify the resider representative(s) of the reasons for the language and mann facility must send a representative of th Long-Term Care Or (ii) Record the reas discharge in the res accordance with pa and (iii) Include in the no paragraph (c)(5) of §483.15(c)(4) Timir (i) Except as specif (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be no before transfer or d (A) The safety of in be endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's h allow a more immed under paragraph (c (D) An immediate to required by the resi	e before transfer. Insfers or discharges a must- Int and the resident's of the transfer or discharge and move in writing and in a mer they understand. The copy of the notice to a le office of the State mbudsman. In ons for the transfer or sident's medical record in largraph (c)(2) of this section; of the notice in this section.  In g of the notice. In g of the notice of transfer or under this section must be lat least 30 days before the led or discharged. In made as soon as practicable	F6	623		5/9/22	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245581	B. WING			C <b>3/31/2022</b>	
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP COI 201 SHADY LANE DRIVE WADENA, MN 56482		0/0 1/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 623	(E) A resident has ridays.  §483.15(c)(5) Continotice specified in produce the foliation of the foliation in the reason for the foliation in the effective data (iii) The effective data (iii) The location to transferred or dischedive to a statement of the including the name, and telephone number of the completing the form hearing request;  (v) The name, address and developmental disabilities, the maintelephone number of the protection and a developmental disabilities, the maintelephone number of the protection and a developmental disabilities, the maintelephone number of the protection and a developmental disabilities, the maintelephone number of the protection and a developmental disabilities of the Developmental disabilities of the Developmental disabilities and Bill of Rights Accodified at 42 U.S.C. (vii) For nursing factories and address and agency responsible advocacy of individual control of the disabilities.	ents of the notice. The written paragraph (c)(3) of this section lowing: ransfer or discharge; the of transfer or discharge; which the resident is arged; which the resident is arged; the resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State mbudsman; lity residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with bilities established under Part ental Disabilities Assistance of 2000 (Pub. L. 106-402, C. 15001 et seq.); and ility residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder the Protection and Advocacy iduals Act.	F6	523			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	COMPLETED	
		245581	B. WING			C <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REH	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	If the information in effecting the transfer must update the reas practicable once becomes available.  §483.15(c)(8) Notice In the case of facility the administrator of written notification in to the State Survey State Long-Term Content to the facility, and the well as the plan for relocation of the reast 483.70(l). This REQUIREMED by:  Based on interview to notify the State Confacility transfer for contraviewed for transfer for the reviewed for transfer for the review of the R8's revealed R8 was at 7/23/21, and readminute for the review of R8's properties of R8's properties for the facility emergency room decrease of the facility emergency room decrease of the facility emergency room decrease of the Ombotics	the notice changes prior to be or discharge, the facility cipients of the notice as soon at the updated information  be in advance of facility closure by closure, the individual who is if the facility must provide prior to the impending closure. Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at §  NT is not met as evidenced of and review, the facility failed ombudsman's office of a one of two residents (R8) ers.  form titled Face Sheet dmitted to the facility on nitted on 1/31/22.	F6	F623- D Notice Requirements Transfer/Discharge The facility failed to notify the Ombudsman of a facility transf resident who was hospitalized returned to the facility.  1. F623 2. The ombudsman was notif resident □s transfer to the hosp (1/30/22) and readmission to F (1/31/22) on 3/30/22. All reside have been transferred within the months were reviewed to ensu notifications were sent to the Otimely.  3. All residents are at risk of the affected by this deficient practicular. Education provided to nurse and social services designee rethe procedure of transferring a	er for one but ied of the ital OL nts who le last three re that imbudsman being ce. ing staff elated to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245581	B. WING		C <b>03/31/2022</b>	
NAME OF F	PROVIDER OR SUPPLIER	240001		TREET ADDRESS, CITY, STATE, ZIP CODE	03/31	12022
NAME OF F	TOVIDER OR SUFFEIER			01 SHADY LANE DRIVE		
FAIR OA	KS NURSING & REHA	AB LLC		VADENA, MN 56482		
1				·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 623	Continued From pa	ge 4	F 623			
	no documentation the Ombudsman had been notified about R8's transfer to the hospital.			out of point click care when he or s sent to the hospital and sending the	e	
	During an interview	on 3/30/22, at 3:10 p.m., the		proper notification to the Ombudsm 5. Audits initiated 4/21/22 to be	ıan.	
		ctor (SSD) indicated the		completed and audited by the DON	lor	
		tion of the Ombudsman was to		designee two times weekly for four		
		g of the month, a list of		then every week for four weeks. Au		
		ed or discharged from the		will be reviewed at QAPI for additio		
		revious month. SSD confirmed ations for the month of		oversight and possible changes ne ensure ongoing compliance.	eded to	
		February 2022, revealed the		DON/designee will be responsitely	ble for	
		een notified that R8 was		compliance.		
	transferred to the h	ospital.		7. This deficiency will be correcte	d	
	During an interview	on 3/30/22, at 3:15 p.m., the		5/9/22.		
		(MDS) Coordinator confirmed				
		from the facility on 1/30/22, at				
		ned to the facility the next day,				
	on 1/31/22, at 6:40	p.m.				
		on 3/30/22, at 3:20 p.m., the				
		the expectation was staff				
		budsman the list of residents				
		onthly basis even if the een gone for one day. The				
		med the notification of the				
	discharge of R8 on	1/30/22, had not been				
	communicated to the	ne Ombudsman.				
	Review of the facilit	ry policy titled Admission,				
		Hold, and Transfer/Discharge				
	dated 1/04/19, reve	aled a copy of the [discharge]				
		t to a representative of the				
T 055		_ong-Term Care Ombudsman.	L 0EC		_	10122
	Baseline Care Plan CFR(s): 483.21(a)(		F 655		5/	/9/22
00-0	51 11(5). 400.21(a)(	., (=)				
	§483.21 Comprehe	nsive Person-Centered Care				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245581		B. WING _			C /31/2022		
	PROVIDER OR SUPPLIER  KS NURSING & REH	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 655	implement a baselii that includes the inseffective and perso that meet profession. The baseline care p(i) Be developed with admission.  (ii) Include the minimal necessary to prope including, but not lir (A) Initial goals base (B) Physician order (C) Dietary orders.  (D) Therapy services.  (E) Social services.  (F) PASARR recommed systems (E) Social services.  (F) PASARR recommed systems (F) PASARR recommed services.  (i) Is developed with admission.  (ii) Meets the require (b) of this section (e) this section (e) this section (e) this section (e) the baseline care limited to:  (i) The initial goals (ii) A summary of the dietary instructions.  (iii) Any services and the inservices and the instructions.  (iii) Any services and the inservices and the instructions.  (iii) Any services and the inservices and the instructions.	e Care Plans facility must develop and ne care plan for each resident structions needed to provide n-centered care of the resident nal standards of quality care. plan must- thin 48 hours of a resident's mum healthcare information rly care for a resident mited to- ed on admission orders. s.  es.  mendation, if applicable. facility may develop a e plan in place of the baseline herehensive care plan- thin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the expresentative with a summary e plan that includes but is not of the resident. The resident's medications and	F 65	5			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	COM	SURVEY PLETED
	<b>245581</b> B. WING			C 03/31/2022		
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 655	on behalf of the fact (iv) Any updated inf of the comprehensi This REQUIREMEN by: Based on interview facility failed to ensicompleted within 48 of four residents (R care plans.  Findings include: Review of R245's fa admitted to the facily which included sepsinjury), osteomyeliti right ankle, and a cleg.  Review of R245's b first two sections, Grunctional Status with The following six sections of Functional Status with following six sections or family representation of the form lacked sign or family representations within 48-hou confirmed R245's been completed.  Review of the facility and the facility of the facilit	ility. ormation based on the details we care plan, as necessary. NT is not met as evidenced and document review, the are a baseline care plan was 3-hours of admission for one 245 reviewed for baseline  ace sheet revealed R245 was atty on 3/25/22, with diagnoses is (infection causing tissue infection of the bone) of the arenic ulcer to the lower left aseline care plan identified the arenal Information and are completed on 3/25/22. Activities, and (BCP) Summary and been completed. Additionally, natures from the resident and attive.  on 3/31/22, at 9:50 a.m., the foursing (ADON) stated staff complete the baseline care ris of admission. ADON aseline care plan had not	F 65	F655- D Baseline Care Plan Facility failed to ensure a baseline plan was completed within 48 hour admission for one resident.  1. F655 2. Baseline care plan for R 245 completed 3/29/22. All residents w admitted within the last week were reviewed to ensure that his or her baseline care plans have been cor timely. 3. All residents are at risk of bein affected by this deficient practice. 4. Education provided to nursing social services designee, therapy of activity director and dietary manag 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 designee one time weekly for four then every other week for one mor Audits will be reviewed at QAPI for additional oversight and possible of needed to ensure ongoing complia 6. DON/designee will be respons compliance. 7. This deficiency will be corrected 5/9/22.	ho have holeted g staff, director, er  Nor weeks, hanges ince. ible for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	X3) DATE SURVEY COMPLETED				
		245581	B. WING		C 03/31/2022		
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC	2	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SHADY LANE DRIVE VADENA, MN 56482	00/01/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 655 F 677 SS=D	2/12/22, revealed a developed within 48 ADL Care Provided CFR(s): 483.24(a)(2) A res	baseline care plan would be hours of admission. for Dependent Residents  2)  ident who is unable to carry	F 655		5/9/22		
	services to maintain personal and oral hand or	y living receives the necessary of good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview and document illed to provide assistance with hich included facial hair esidents (R17 and R30) who with grooming and personal imum Data Set (MDS) dated R17 had diagnoses which depression, and end stage MDS identified R17 had pairment, required extensive sonal hygiene and was totally ities of daily living (ADL's) of ig. The MDS revealed R17 cares during the seven day		F677- D ADL Care Provided for Dependent Residents Facility failed to provide assistance varoutine grooming which included facinar removal for two residents who required assistance with grooming a personal hygiene.  1. F667 2. Facial hair was shaved, and fingernails were cleansed and trimm R17 and R30. All other residents assessed for shaving needs and sha as required. All residents are at risk obeing affected by this deficient practice. 3. All residents are at risk of being affected by this deficient practice. 4. Education provided to nursing stand activity staff related to the import of shaving per resident □s needs or	ed for aved of ice.		
	had an ADL deficit, dressing, bathing a care plan directed f and to attempt to tri necessary and pref	ised 1/26/22, identified R17 required assistance with and personal hygiene. R17's acility staff to check nail length m and clean on bath day, as erred to have long nails. R17's rection and preferences for		desires.  5. Audits initiated 4/21/22 to be completed and audited by the DON designee three times weekly for four weeks, then weekly for one month. A will be reviewed at QAPI for review. audits determine whether the resider	Audits The		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245581	B. WING			C <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA	21000		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		31/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	laying on her back is covered with a blanchest. R17 had sev (5) to seven (7) mill wispy chin hairs and three (3) mm long, her chin, upper lip at On 3/29/22, at 9:45 seated in a tilt in sp wheelchair for positive eyes closed. R17 for over the bed, rolling R17 continued to he 5-7 mm long, white dozen 2-3 mm long along her chin, upper mouth. R17's handsher fingernails were length, were jagged nail polish and were brownish substance ten of her fingernail.  - at 2:38 p.m. during laying on her back is blanket up to her chozens of approxim wispy chin hairs and thick, black, course and corners of her inher chest, all ten or approximately 2-3 rinad chipped mauve observed to have a	p.m. R17 was observed n bed, eyes were closed, ket from her feet to upper eral dozen, approximately five imeters (mm) long, white, d several dozen, two (2) to thick, course black hair along and corners of her mouth.  a.m. R17 was observed ace wheelchair (specialized ioning) in her room with her aced the doorway, she had an a table placed in front of her. ave dozens of approximately, wispy chin hairs and several, thick, black, course hairs er lip and corners of her is rested on her lap, all ten of approximately 2-3 mm of l, had chipped mauve colored to observed to have a thick a underneath the length of all	F 6	was shaved, if they refused to if their care plan was updated to her preference in shaving, if than every day.  6. DON/designee will be resp compliance.  7. This deficiency will be corres/9/22.	o reflect his different onsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245504	B. WING		С	
NAME OF I	200//050 00 01/00//50	245581	D. WING		03/3	31/2022
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  201 SHADY LANE DRIVE  WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		) BE	(X5) COMPLETION DATE
F 677	R17 was laying in be closed and was covered feet to her chin. At the (NA)-E and NA-C, or proceeded to assist was assisted from the wheelchair, NA-E per R17 continued to has 5-7 mm long, white dozen 2-3 mm long along her chin, upper mouth. R17's finger and had a thick broathelength of all ten at 9:46 a.m. during remained seated in room with an over the R17 continued to has 5-7 mm long, white dozen 2-3 mm long along her chin, upper mouth. R17's finger and had a thick broathelength of all ten at 11:51 a.m. during seated in a tilt in specific positioned to face the have dozens of approximate white, wispy chin has long, thick, black, cupper lip and corner fingernails continued.	a.m. during an observation, sed on her back, eyes were vered with a blanket from her that time, nursing assistant entered R17's room and to R17 with morning cares. R17 her bed to a tilt in space roceeded to brush R17's hair. ave dozens of approximately, wispy chin hairs and several, thick, black, course hairs er lip and corners of her mails continued to be jagged, which substance underneath fingernails.  If an observation, R17 a tilt in space chair in her he bed table in front of her. ave dozens of approximately, wispy chin hairs and several, thick, black, course hairs er lip and corners of her mails continued to be jagged, which substance underneath fingernails.  In gan observation, R17 was ace chair in her room, he doorway. R17 continued to broximately 5-7 mm long, her doorway. R17 continued to broximately 5-7 mm long, her sand several dozen 2-3 mm ourse hairs along her chin, rs of her mouth. R17's her do be jagged, and had a stance underneath the length	F 6	577		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245581	B. WING			C <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 677	NA-E indicated R17 ADL's, which include and bathing. NA-E is was able to verbaliz staff were to anticiped did not offer to remend attempt to provide was not aware of facial hair removal a responsible for R17 On 3/30/22, at 12:3 NA-C stated R17 wher ADL's of dressin and all mobility. NA offered to have her morning cares and NA-C indicated R17 on her bath day and NA-C stated she was substance was und indicated she was resubstance had been fingernails.  On 3/30/22, at 12:5 licensed practical in had dozens of 5-7 rhairs and several deblack, course hairs corners of her mout R17's fingernails we brownish substance ten fingernails. LPN important to R17 to	a.m. during an interview, was totally dependent for all ed dressing, personal hygiene indicated he did not feel R17 be her needs or wishes and ate her needs. NA-E stated he ove R17's facial hair and did de nail care. NA-E indicated if R17's preferences regarding and was not sure who was 's nail care.  7 p.m. during an interview, as totally dependent for all of ng, bathing, personal hygiene -C confirmed R17 was not facial hair removed during had not been offered since. T's nail were cleaned and filed d as needed by other staff. as not sure what the brown erneath R17's nails and not sure how long the	F 6	77		
	indicated R17 used appearance prior to	to take pride in her her dementia diagnosis.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245581	B. WING			C 31/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE	1 03/	31/2022
FAIR UA	KS NURSING & REHA	AB LLC		WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG		BE .	(X5) COMPLETION DATE
F 677	assistant director of felt R17 did not like fingernails, preferredifficult to keep her ADON stated she fel have her facial hair activity staff had becares such as nail cother grooming and how to document restated she would explayed allow.  On 3/31/22, at 9:23 interview, R17's fan prior to R17's demerpride in her overall amanicured fingernal spoken to facility state concerns with R17's appearance. FM-A assisted to remove groomed on a daily  On 3/31/22, at 9:27 activity director (AD offered nail care an 3/28/22, and had rewas unaware if R17 with shaving or nail her refusal. AD-A states.	a.m. during an interview the foursing (ADON) stated she anyone to touch here determined them long and felt it was nails well manicured. The left R17 likely had refused to removed, indicated the facility en assisting with resident care, facial hair removal and felt they were not aware of esident refusals. The ADON expect R17 to be offered to be her nail care provided as a.m. during a telephone of the had aff in the past year about a facial hair, nails and overall estated he expected R17 be her facial hair and be well	F 6	,		
	R30					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245581	B. WING					C 31/2022
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDR 201 SHADY L WADENA, M		DDE	007	01/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF COR CH CORRECTIVE ACTION S-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 677	3/3/22, identified R3 included dementia, the knee amputation had severe cognitive extensive assistance (ADL's) of dressing totally dependent for R30 had no rejection assessment period R30's care plan revelocated had an ADL self care with dressing, bathic care plan did not identificate plan did not have a would shave his fact R30 liked to have a would shave his fact R30 had a mustach did not have a bear shaven. FM-B indice R30's wife had voice appearance. She in unkept, he was unsappearance. FM-B nursing and had no concerns regarding On 3/28/22, at 5:18 laying in bed on his was covered with a extremities up to his was covered with the stubble approximate.	imum Data Set (MDS) dated 30 had diagnoses which anxiety and bilateral above ns. The MDS identified R30 re impairment and required with activities of daily living personal hygiene and was or bathing. The MDS identified on of cares during the rised 3/24/22, revealed R30 re deficit, required assistance ng, and personal hygiene. The entify R30's facial hair or	F	77				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245581	B. WING		03	C /31/2022
	PROVIDER OR SUPPLIER  KS NURSING & REH			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		10 1/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	laying in bed on his closed and was covered white properties of the state of the st	age 13  31 a.m. R30 was observed back in a low bed, eyes wered with a blanket up to the 30 continued to have thick, facial stubble, approximately 19 his cheeks, chin, neck and was observed seated in a tilt in 19 com and faced the window. The area were elementary oximately 2-3 mm long, along eck and around his mouth.  4 a.m. R30 was observed in his back, eyes were closed with a blanket up to the top of tinued to have thick, course, subble, approximately 3 to four his cheeks, chin, neck and was observed seated in a tilt in 19 common area of the unit. The area were opened, he was covered to his chin. R30 continued to white/gray facial stubble, four (4) mm long, along his and around his mouth.  3 p.m. nursing assistant (NA)-Eally dependent for all ADL's, ally dependent for all ADL's,	F6	777		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  G		E SURVEY PLETED
		245581	B. WING			31/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE	03/-	51/2022
FAIR OA	KS NURSING & REHA	AB LLC		WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 14	F 67	7		
	bathing. NA-E indic	ssing, personal hygiene and ated R30 was shaved twice not shaved R30 in the past				
	(LPN)-A confirmed appeared R30 had days. LPN-A indicat	p.m. licensed practical nurse R30's facial hair, indicated it not been shaved for a few ted R30 preferred to be clean have been shaved daily.				
	stated she felt R30 routinely refused ca indicated R30 histo with staff and could She indicated she v	p.m. the facility administrator had refused shaving and ares. The administrator rically was verbally aggressive be very difficult to work with was not aware if staff were refusals, though would expect Il refusals of care.				
	(AD)-A stated R30 v 3/28/22, and was of The AD-A indicated been offered to sha	a.m. the activity director was approached on Monday, ffered shaving at that time. she was not aware if R30 had we any other days during the would assist if he allowed.				
	(ADL's) revised 3/1 assessment and refacility must provide services. The policy provide the followin	d, Activities of Daily Living 5/21, identified based on sident needs and choices, the e the necessary care and revealed the facility would g ADL's, which included dressing, grooming and oral				
F 695 SS=D		ostomy Care and Suctioning	F 69	5		5/9/22

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245581	B. WING _		C <b>03/31/2022</b>	
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482	00/01/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉT	
F 695	§ 483.25(i) Respirat tracheostomy care The facility must en needs respiratory care and tracheal s care, consistent wit practice, the compressed on the resid and 483.65 of this series. This REQUIREMENT by:  Based on observative review, the facility for continuous (CPAP) (delivers ox through a mask and four residents (R24). Findings include:  Review of R24's sign Data Set (MDS) data was admitted on 12 and used a CPAP.  Review of R24's faci identified R24 had a sleep apnea (sleep repeatedly stops and Review of R24's phhealth record (EHR CPAP on while sleep home settings was lacked a physician's During an observation R24 was observed.	tory care, including and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced ion, interview, and document alled to obtain a physician's s Positive Airway Pressure tygenated air into the airways d a tube) therapy for one of previewed for respiratory care.  Inificant change Minimum and the dof 2/28/22, identified R24 and diagnosis of obstructive disorder where breathing	F 69	F695- D Respiratory/Tracheostom and Suctioning Facility failed to obtain a physician order for Continuous Positive Airwa Pressure (CPAP) therapy for one reviewed for respiratory care.  1. F695 2. Order for CPAP was obtained of for R24. All other residents with obstructive sleep apnea were revieced CPAP orders. 3. All residents with sleep apnea was CPAPs are at risk of being affect this deficient practice. 4. Education provided to nursing related to the importance of having CPAP order in place for a resident requires a CPAP. 5. Audits initiated 4/21/22 to be completed and audited by the DON designee once weekly for four weee every other week for one month. All will be reviewed at QAPI for review 6. DON/designee will be responsicompliance. 7. This deficiency will be corrected 5/9/22.	y y esident 3/31/22 wed for who cted by staff a who or ks then udits ble for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245581	B. WING		C	
NAME OF F	PROVIDER OR SUPPLIER	240001	J	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	31/2022
FAIR OA	KS NURSING & REHA	AB LLC		201 SHADY LANE DRIVE		
.,				WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	R24 was observed and the CPAP mac on his overbed tabl During an observat R24 was observed on. During an interview assistant director of was not certain why CPAP and believed off" when R24 retur 3/14/22.  During an observat the ADON revealed observed to be set 9.0-12.0 pressure.  During a follow-up if a.m. the ADON was which had since be included the "home	sitting on the edge of his bed hine was located next to him	F 6	95		
F 880 SS=D	Use dated 08/01/15 CPAP/BiPAP would include approved o and use of humidific supporting diagnos Infection Preventior CFR(s): 483.80(a)( §483.80 Infection CThe facility must estinfection prevention designed to provide	n & Control 1)(2)(4)(e)(f)	F 8	80		5/2/22

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETED
		245581	B. WING			C / <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		01/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 880	development and tr diseases and infect §483.80(a) Infectior program. The facility must es and control program a minimum, the following services in the facility reporting, investigating and communicable staff, volunteers, visproviding services in the facility accepted national services for the put are not limited to (i) A system of survices are not limited to (ii) A system of survices for the put are not limited to (ii) A system of survices for the persons in the facility (iii) When and to who communicable diserveported; (iii) Standard and trate to be followed to profit (iv) When and how it resident; including to (A) The type and dudepending upon the involved, and (B) A requirement to	ansmission of communicable ions.  In prevention and control  tablish an infection prevention (IPCP) that must include, at owing elements:  Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment g to §483.70(e) and following tandards;  en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be used for a	F8	380		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY PLETED
		245581	B. WING			03/3	3 31/2022
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		201	REET ADDRESS, CITY, STATE, ZIP CODE SHADY LANE DRIVE LDENA, MN 56482	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	(v) The circumstand must prohibit employing disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in the staff involved involved in the staff involved inv	ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.  Item for recording incidents facility's IPCP and the taken by the facility.  Indle, store, process, and the taken by the facility.  Indle, store, process, and the taken by the spread of the	F8		F880- D Infection Control and Pre Facility failed to ensure PPE was under when providing direct care of three residents who were in droplet precondition, facility failed to ensure resident catheter collection bag wastored in a manner to prevent infection of two reviewed for urinary catholic transportation. The cone of two reviewed for urinary catholic transportation and covered as appropriate with a catholic transportation of the cook of the appropring the transportation of the surveyor on 3/3 reminding the cook of the appropring the transportation in the cook of the appropring the cook of the appropring the transportation in the cook of the appropring the cook of the cook o	sed of five autions. s stion for heters. tion) was eter erbally navior in 30/22, ate	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			SURVEY LETED
		245581	B. WING		03/3	1/2022
	PROVIDER OR SUPPLIER	AB LLC	2	TREET ADDRESS, CITY, STATE, ZIP CODE 101 SHADY LANE DRIVE VADENA, MN 56482	1 00/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	2/10/22, identified I included dementia, renal disease. The severe cognitive imassistance with per dependent for active dressing and bathin Review of R17's nual/27/22, identified I required as needed breath. A later note precautions for upper country and observations for upper country was noted to be eyes were closed, her feet to upper claminated eight (8) which identified R1 precautions, and rewar and gloves was required for ercontainer and a be positioned outside gloves, gowns, two grade masks and container and a be positioned outside gloves, gowns, two grade masks and container and a wear and gloves was required for ercontainer and a be positioned outside gloves, gowns, two grade masks and container and a wear and contact a placed which identified worn. A four drawe bedside table were	R17 had diagnoses which depression, and end stage MDS identified R17 had apairment, required extensive resonal hygiene and was totally vities of daily living (ADL's) withing.  Irsing progress notes dated R17 had wheezing and dinhalers for shortness of revealed R17 was placed on per respiratory symptoms.  Ition on 3/28/22, at 4:48 p.m. be laying on her back in bed, covered with a blanket from nest. R17's door had a by 11 inch laminated sign 7 was on contact and droplet evealed a mask, gown, eye ere required to enter the room. I sign, identified an N95 mask aftry. A four drawer plastic diside table were also of R17's room, which held a types of N95 masks, medical disinfecting wipes with	F 880	require droplet precautions, including R249. NA-E donned an appropriate mask when he located them in the outside of R17 s door on 3/30/22. was verbally educated on 3/30/22 importance of donning all appropriate PPE prior to entering an isolation residuding R245 s, even if just make bed.  3. Residents and their represental received education on the facility sinfection prevention control program related to them and to the degree possible/consistent with resident scapacity. All residents who require and/or droplet precautions and all residents with catheters could be a by this deficient practice.  4. The QAPI team and/or designed conducted a root cause analysis to identify the problem that resulted in deficiency. The Infection Prevention DON reviewed policies and proced for donning/doffing PPE, during Cowith current guidelines to include of standard of care, contingency standard of care, contingency standard and transmission-based precautions. A residents with catheters were reviewed ensure physician orders and care payed instruction on placement and storage of the catheter collection be and all staff who enter resident and storage of the catheter collection control practices, including but not limited and related to standard infection control practices. including but not limited and storage including but not limited and related to standard infection control practices. including but not limited and storage including but not limited.	e N95 drawer NA-D of the ate oom, ing a atives s m as it s contact ffected ee, n this nist and lures ovid-19 risis dard of nd ks and III ewed to olans ags. are staff rooms	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY IPLETED
		245581	B. WING _			C <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETION DATE
F 880	types of N95 mask disinfecting wipes of N95 mask disinfecting wipes of N95 mask disinfecting wipes of N95 was noted to be covered with a blue doorway continued contact and droplet an N95 was required plastic container are positioned outside gloves, gowns, two grade masks and contact and proceeded to be eyes were closed as from her feet to her assistant (NA)-E are and proceeded to a NA-E had on eye proceeded to a NA-E not	ion on 3/29/22, at 2:38 p.m. be laying on her back in bed, blanket up to her chin. R17's to have signs, identifying a precautions which identified ed to be worn. A four drawer and a bedside table were also of R17's room, which held a types of N95 masks, medical lisinfecting wipes with  ion on 3/30/22, at 8:14 a.m. be laying in bed on her back, and was covered with a blanket or chin. At that time, nursing and NA-C, entered R17's room assist R17 with morning cares. To tection, a medical grade a disposable gown, NA-C wore N95 mask, gloves and a and both proceeded to assist	F 88	transmission-based precaution appropriate PPE use, and done doffing of PPE. Training include competency testing of staff when documented via attestation state completion. Furthermore, educe provided to direct care staff relevances to overall catheter care, placements storage.  6. The DON, Infection Prever and/or designee will conduct reaudits of donning/doffing PPE with transmission-based precautions shifts four times a week for one then twice weekly for one week compliance is met. Real time a also include aerosolized generates procedures and proper use of generate PPE is in use. Audits with until 100% compliance is met control masking for staff, visito residents. Audits will be review for review. Catheter care audits on 5/2/22 to be completed and the DON or designee three tim for four weeks, then weekly for month. Audits will be reviewed review.  7. DON/Infection Preventionis responsible for compliance.  8. This deficiency will be corresponsible for compliance.	aing and ed ch was rement of ation was reted to at all-time with son all executions will ating gowns to all continue on source as, and red at QAPI initiated audited by es weekly one at QAPI for at/Designee	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	СОМ	E SURVEY IPLETED
		245581	B. WING			C <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482	1 03/	31/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	During an interview stated R17 was on precautions and incomplete protection and was not able to weathere were none aviour drawer plastic room, pulled the se several dozen N95 pull the third drawer another several dozindicated he had not entering R17's room.  During an interview NA-C stated R17 with droplet precautions respiratory symptom was required to be changed to another vaccinated and and leaving R17's room.  During an interview LPN-B confirmed R17's morning indicated had she in did not notice what when R17's morning indicated had she in grade mask on, she education and had.  During an interview facility infection prehad been placed or	on 3/30/22, at 8:43 a.m. NA-E contact and droplet dicated staff were to wear the ering her room; gown, gloves, an N95 mask. NA-E stated he ar an N95 into R17's room, as ailable. NA-E then moved to a container outside of R17's cond drawer open, revealed masks. NA-E proceeded to ropen, which revealed zen N95 masks. NA-E of checked the drawers before in.  on 3/30/22, at 12:37 a.m. as currently on contact and due to a cough and other ins. NA-C indicated an N95 worn in R17's room, and mask, (medical grade if other N95 if unvaccinated) after	F 88			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TPLE CONSTRUCTION  NG		E SURVEY PLETED
		245581	B. WING_			C 31/2022
	PROVIDER OR SUPPLIER	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  201 SHADY LANE DRIVE  WADENA, MN 56482	1 00.	1/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	tested negative for were required to we precaution rooms, a eye protection.  R249  Review of R249's fa health record (EHR admitted to the facion of R249's in EHR identified R24 the recommended of Therefore, R249 was Droplet Precautions.  During an observation R249's room revearead "Contact and I signs indicated staff don (put on) eye progown, and gloves don prior to entering set of drawers outs.  During an observation of drawers outs.  During an observation of drawers outs.  During an observation of drawers outs.  During an interview was done of drawers of drawers outs.  During an interview was done of drawers of drawers outs.	COVID-19. The IP stated staff ear an N95 in contact/droplet along with gowns, gloves, and acce sheet in the electronic ), revealed R249 was lity on 3/24/22.  Immunizations record in the 9 was not up to date with all COVID-19 vaccine doses. as placed on Contact and is upon admission.  Ion 3/29/22, at 11:12 a.m. of led signs on the door which Droplet Precautions." The fentering the room were to obtection, N95 mask, isolation The supplies for the staff to g the room were located in a lide the room.  Ion on 3/29/22, at 10:56 a.m., NA)-D entered R249's room, the bed in the room without	F 88	30		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION  NG	CON	TE SURVEY MPLETED
		245581	B. WING			C / <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA	AB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 201 SHADY LANE DRIVE WADENA, MN 56482	<b>.</b>	10112022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	Review of R245's farevealed R245 was 3/25/22.  Review of R245's in EHR revealed R245 the recommended of Therefore, R245 was Droplet Precautions.  During an observation R245's room had singuity indicated staff enterprotection, N95 mand The supplies for the the room were locating the Cook (C)-A was serving R245 a lungown.  During an interview director of nursing (observed C-A in R2 tray without wearing confirmed C-A shout on Contact and Drople indicated staff enterprotection, N95 mand The supplies for the treatment of the room.  During an observation of the cook (C)-A was serving R245 a lungown.  During an interview director of nursing (observed C-A in R2 tray without wearing confirmed C-A shout on Contact and Drople indicated upon admiresidents who were vaccinations would	ace sheet in the EHR, admitted to the facility on mmunizations record in the was not up to date with all COVID-19 vaccine doses. as placed on Contact and supon admission.  Jon on 3/28/22, at 4:45 p.m. agns on the door which read et Precautions." The signs ring the room were to don eye sk, isolation gown, and gloves. As staff to don prior to entering ted in a set of drawers outside and on 3/29/22, at 12:11 p.m., as observed in R245's room ch tray while not wearing a con 3/29/22, at 12:12 p.m., the DON) indicated she had was room serving the lunch gan isolation gown. The DON all dhave donned a gown prior room due to the resident being	F 88	80		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION  NG	CON	TE SURVEY MPLETED
		245581	B. WING			C / <b>31/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REH	AB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	Precautions revised transmission-based when transmission prevented by stand facility was expected door or wall outside indicating the type opersonal protective.  Catheter Care  R30's quarterly Min 3/3/22, identified R3 included dementia, amputations and obidentified R30 had and required extensof daily living (ADL'hygiene and was to The MDS identified catheter.  R30's current physifor a supra pubic caconnection between skin used to drain undividuals with obsiflow), catheter care	ty policy titled Isolation d 6/23/20, identified d precautions would be used could not be reasonably ard precautions alone and the ed to post clear signage on the e of the resident room of precautions and required	F8	,		
	the catheter collect R30's current care R30 required a sup significant urinary r uropathy. The care	cked direction on placement of ion bag.  plan revised 3/24/22, revealed ra pubic catheter due to etention and obstructive plan lacked instructions for a catheter collection bag.				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245581	B. WING		03	C 3/31/2022
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS NURSING & REHAB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 201 SHADY LANE DRIVE WADENA, MN 56482		10112022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880	During an observation R30 was noted to be bed, his eyes were with a blanket from mid chest. R30's cafrom underneath the bed, and lead to a condition of the directly on a fall material and a control of the lowered to grow closed and he was catheter collection to a fall material and the directly on a fall material and the lowered to grow closed and he was catheter collection to a fall material and the lowered with a blank R30's catheter collection and the lowered with a blank R30's catheter collection.  During an observation on the floor.  During an observation on the floor.  During an observation of the left signation on the floor.  During an observation of the lower displaying on the left signation of the floor.  Lat 9:33 a.m. R30 is a lower displaying directly on a signature of the lower displaying displaying displaying displaying di	ion on 3/28/22, at 5:18 p.m. e laying on his back in low closed and he was covered his lower extremities to his atheter tubing was observed e blanket on the left side of his collection bag which laid ton the floor.  was observed to remain laying n a low bed (bed that is able bund level), his eyes were covered with a blanket. R30's bag remained laying directly floor.  ion on 3/29/22, at 10:51 a.m. the laying in bed on his back, in wes were closed, he was ket up to the top of his chest. Section bag was observed de of his bed, directly on a fall tion on 3/30/22, at 7:34 a.m. the laying in bed on his back, in we laying in bed on his back, in the left side of his bed, fall mat on the floor.  was observed laying on his his eyes were closed and he blanket from his legs to his er collection bag, half full of observed laying directly on a	F 8	80		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245581	B. WING		0:	C 3/31/2022
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS NURSING & REHAB LLC				STREET ADDRESS, CITY, STATE, ZIP COD 201 SHADY LANE DRIVE WADENA, MN 56482		310 11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 880	back in a low bed, I catheter collection the floor on the left observed in the bag mat on the floor.  During an interview stated R30 was total which included dress bathing. NA-E indicated received catheter of the collection bag with bladder, on the growheelchair. NA-E with for R30's catheter of the collection of the plastic catheter collection of the plastic catheter bag catheter collection black bag and place left side of R30's be brought the catheter few days ago. She prevented the catheter completely off the format on the plastic catheter catheter collection black bag and place left side of R30's be brought the catheter few days ago. She prevented the catheter completely off the format on the plastic catheter catheter catheter catheter catheter few days ago. She prevented the catheter completely off the format on the plastic catheter	ris eyes were opened. R30's bag was observed laying on side of his bed, no urine was g, which lied directly on a fall on 3/30/22, at 2:23 p.m. NA-E ally dependent for all ADL's, ssing, personal hygiene and sated R30 had a catheter, ares twice daily and indicated was to be placed below R30's und or underneath R30's was unaware of any cover used		380		
	infection prevention expect resident cat placed in a cover a possible. IP stated	on 3/31/22, at 8:46 a.m. the nist (IP) stated she would heter collection bags to be nd kept off the floor if at all R30 had a low bed, which eter from being off the floor,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245581	B WING				04/0000
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, 2	ZIP CODE	03/-	31/2022
FAIR OA	KS NURSING & REHA	ARII C		201 SHADY LANE DRIVE			
TAIR OA				WADENA, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 880	· ·	_	F 8	80			
		eted the collection bag to be e possible infection control					
	A facility policy titled Management, revis bags would be cove	ed 11/4/20, identified catheter					



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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Fair Oaks Nursing & Rehab Llc April 18, 2022 Page 2

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

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

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

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

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  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
22270		B. WING		C <b>03/31/2022</b>		
NAME OF I	PROVIDER OR SUPPLIER	00679		CTATE ZID CODE	03/3	51/2022
		201 SHΔΓ	DY LANE DR	STATE, ZIP CODE I <b>VE</b>		
FAIR OA	KS NURSING & REHA	AB LLC WADENA	, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall I	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag le number indicated below. It is several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your faminnesota Departm facility was found N State Licensure and orders are issued. F	FS: /22, a licensing survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN d the following correction Please indicate in your orrection you have reviewed				

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

(X6) DATE TITLE Electronically Signed 04/27/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING	A. BUILDING:			
		00679	B. WING			C <b>31/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY,	STATE, ZIP CODE		
FAIR O	AKS NURSING & REH	ABIIC	ADY LANE DR A, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	age 1	2 000			
	these orders and id be completed.	dentify the date when they will				
	00 Continued From page 1 these orders and identify the date when they will					

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 2 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00679	B. WING		C 03/31/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/0	7172022
FAIR OA	KS NURSING & REHA	AB LLC	Y LANE DR , MN 56482	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			5/9/22
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	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.			No POC required.		
	2/10/22, identified F included dementia, renal disease. The severe cognitive im assistance with per dependent for activ dressing and bathir had no rejection of look back period.	imum Data Set (MDS) dated R17 had diagnoses which depression, and end stage MDS identified R17 had pairment, required extensive sonal hygiene and was totally ities of daily living (ADL's) of ng. The MDS revealed R17 cares during the seven day				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 3 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00679	B. WING			3 <b>1/2022</b>
	PROVIDER OR SUPPLIER	ABILC 201 SHAD	DRESS, CITY, S DY LANE DRI , MN 56482	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 920	had an ADL deficit, dressing, bathing at care plan directed f and to attempt to tri necessary and pref care plan lacked directed facial hair removal.  On 3/28/22, at 4:48 laying on her back is covered with a blan chest. R17 had sev (5) to seven (7) mill wispy chin hairs and three (3) mm long, her chin, upper lip at the covered with a blan chest. R17 had sev (5) to seven (7) mill wispy chin hairs and three (3) mm long, her chin, upper lip at cover the bed, rolling R17 continued to has 5-7 mm long, white dozen 2-3 mm long along her chin, upper mouth. R17's hands her fingernails were length, were jagged nail polish and were brownish substance ten of her fingernail.  - at 2:38 p.m. during laying on her back is blanket up to her chin covers of approxim wispy chin hairs and thick, black, course	required assistance with and personal hygiene. R17's acility staff to check nail length im and clean on bath day, as erred to have long nails. R17's rection and preferences for  p.m. R17 was observed in bed, eyes were closed, ket from her feet to upper eral dozen, approximately five imeters (mm) long, white, diseveral dozen, two (2) to thick, course black hair along and corners of her mouth.  a.m. R17 was observed ace wheelchair (specialized cioning) in her room with her aced the doorway, she had an grable placed in front of her. ave dozens of approximately, wispy chin hairs and several, thick, black, course hairs er lip and corners of her is rested on her lap, all ten of approximately 2-3 mm of I, had chipped mauve colored to observed to have a thick a underneath the length of all	2 920			

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 4 of 23

AND PLAN OF CORRECTION IDENTIFICATION NOWBER. A. BUILDING:	COMPLETED
	С
00679 B. WING	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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN O PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETE D THE APPROPRIATE DATE
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 higher and several dozen 2-3 mm long, thick, black, course hairs along her chin, upper lip and corners of her mouth. R17's	

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 5 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00679	B. WING			C <b>31/2022</b>
NAME OF PROVIDE	R OR SUPPLIER	STREE	ET ADDRESS, CITY, S	STATE, ZIP CODE		
FAIR OAKS NUF	RSING & REH	ABIIC	SHADY LANE DRI ENA, MN 56482	VE		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
fingerithick is of all to all	orownish substen fingernails and 22, at 8:43 indicated R17, which includations at the control of	ed to be jagged, and had a stance underneath the lengs.  B a.m. during an interview, was totally dependent for ded dressing, personal hygicindicated he did not feel R1 ze her needs or wishes and pate her needs. NA-E stated nove R17's facial hair and divide nail care. NA-E indicate of R17's preferences regard and was not sure who was	all ene 7 d he d d ling of ne ded			

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 6 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED				
	00679		B. WING			C <b>31/2022</b>			
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE		0 11 20 22			
FAIR OA	FAIR OAKS NURSING & REHAB LLC 201 SHADY LANE DRIVE								
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	N, MN 56482	PROVIDER'S PLAN OF CORE	RECTION	(VE)			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE			
2 920	Continued From pa	ge 6	2 920						
	her nails, neatly pai indicated R17 used appearance prior to On 3/31/22, at 8:37 assistant director of felt R17 did not like fingernails, preferre difficult to keep her ADON stated she followed her facial hair	nted and filed. LPN-B to take pride in her her dementia diagnosis.  a.m. during an interview the f nursing (ADON) stated she anyone to touch her d them long and felt it was nails well manicured. The elt R17 likely had refused to removed, indicated the facility							
	cares such as nail of other grooming and how to document restated she would expend the state of	en assisting with resident care, facial hair removal and I felt they were not aware of esident refusals. The ADON expect R17 to be offered to be her nail care provided as							
	interview, R17's fan prior to R17's deme pride in her overall manicured fingerna spoken to facility st concerns with R17's appearance. FM-A	a.m. during a telephone nily member (FM)-A stated entia diagnosis, she had taken appearance and had well ils. FM-A indicated he had aff in the past year about a facial hair, nails and overall stated he expected R17 be her facial hair and be well basis.							
	activity director (AD offered nail care an 3/28/22, and had re was unaware if R17 with shaving or nail her refusal. AD-A st	a.m. during an interview, b)-A stated R17 had been d shaving on Monday, fused. AD-A indicated she had been offered assistance care on any days following tated R17 had been assisted ng interview with nursing staff							

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 7 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:  A. BUILDING:					
		B. WING			
	00679	B. WING		03/3	1/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR OAKS NURSING & REHA	ABIIC	OY LANE DR , MN 56482	VE		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
3/3/22, identified R3 included dementia, the knee amputation had severe cognitive extensive assistance (ADL's) of dressing totally dependent for R30 had no rejection assessment period.  R30's care plan reverse had an ADL self care with dressing, bathing care plan did not indicate plan did not indicate plan did not indicate plan did not have a would shave his fact R30 liked to have a would shave his fact R30 had a mustace did not have a bear shaven. FM-B indicate R30's wife had voice appearance. She in unkept, he was unsuppearance. FM-B nursing and had no concerns regarding.  On 3/28/22, at 5:18 laying in bed on his was covered with a extremities up to his was covered with the stubble approximate.	imum Data Set (MDS) dated 30 had diagnoses which anxiety and bilateral above ns. The MDS identified R30 re impairment and required se with activities of daily living personal hygiene and was or bathing. The MDS identified on of cares during the rised 3/24/22, revealed R30 re deficit, required assistance ng, and personal hygiene. The entify R30's facial hair or	2 920			

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 8 of 23

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  201 SHADY LANE DRIVE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO. A. BUILDING:		COMPLE				
FAIR OAKS NURSING & REHABILIC 201 SHADY LANE DRIVE			00679	B. WING			_
FAIR OAKS NURSING & REHAB LLC	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WADENA, MN 56482	FAIR OA	AKS NURSING & REH	ABIIC		VE		
	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
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.  - 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	neck and upper lip.  On 3/29/22, at 10:5 laying in bed on his closed and was covered white per lip.  -at 3:46 p.m. R30 which space chair in his re R30 continued to he facial stubble, apprhis cheeks, chin, neck states of the per lip.  On 3/30/22, at 7:34 laying in his bed, or and was covered whis chest. R30 continued to he facial stubble, apprhis cheeks. R30 continued to he facial stubble, apprhis cheeks. R30 continued to he facial stubble, apprhis cheeks, chin, neck states of the per lip.  -at 11:44 a.m. R30 in space chair in the R30 continued to he facial stubble, apprhis along his cheeks, comouth.  - at 2:22 p.m. R30 whis back, his eyes which a blanket up to have thick, course, approximately 3 to cheeks, chin, neck.  On 3/30/22, at 2:23	and an				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 9 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY
		00679	B. WING		03/3	C 8 <b>1/2022</b>
	PROVIDER OR SUPPLIER  KS NURSING & REHA	ABILC 201 SHAD	DRESS, CITY, S DY LANE DR , MN 56482	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 920	which included dres bathing. NA-E indic weekly and he had couple of days.  On 3/30/22, at 2:40 (LPN)-A confirmed appeared R30 had days. LPN-A indicates shaven and should  On 3/31/22, at 8:46 stated she felt R30 routinely refused caindicated R30 histo with staff and could She indicated she vidocumenting R30's staff to document a  On 3/31/22, at 9:30 (AD)-A stated R30 vistaff to document and refacility policy titled (ADL's) revised 3/1 assessment and refacility must provide services. The policy provide the followin	ssing, personal hygiene and ated R30 was shaved twice not shaved R30 in the past p.m. licensed practical nurse R30's facial hair, indicated it not been shaved for a few ted R30 preferred to be clean have been shaved daily.  p.m. the facility administrator had refused shaving and ares. The administrator rically was verbally aggressive be very difficult to work with. was not aware if staff were refusals, though would expect	2 920			
	director of nursing ( review and revise p	HOD OF CORRECTION: The DON) or designee could olicies and procedures related living. The director of pursing				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 10 of 23

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00670	B. WING		C <b>03/31/2022</b>	
		00679			03/3	31/2022
	PROVIDER OR SUPPLIER	201 SHAD	Y LANE DR	STATE, ZIP CODE IVE		
FAIR OA	KS NURSING & REHA	AB LLC	MN 56482	··-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 10	2 920			
	staff and develop a staff are providing a daily living.	develop a system to educate monitoring system to ensure assistance with activities of R CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			5/9/22
	control program mu procedures which pare collection to identify residents;  B. a system for control of outbreaks.  C. isolation and reduce risk of trans.  D. in-service exprevention and con.  E. a resident he immunization progration of the procedures of resident the procedures of resident the prevention and formulation. F. the development of the procedures of the procedures of resident of the procedures of the procedures of resident of the procedures of the	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of policies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and				

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00679		B. WING		1/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/3	112022
		201 SHAD	Y LANE DR	•		
FAIR OA	KS NURSING & REHA	AB LLC	MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 11	21390			
	by: Based on observati review, the facility for protective equipme providing direct care R245 and R249) wh In addition, the facil catheter collection is	ent is not met as evidenced on, interview and document ailed to ensure personal nt (PPE) was used when e for 3 of 5 residents (R17, no were in droplet precautions. ity failed to ensure resident oag was stored in a manner to r 1 of 2 residents (R30) y catheters.		No POC required.		
	Findings include:					
	Transmission Base	d Precautions				
	R17					
	2/10/22, identified F included dementia, renal disease. The severe cognitive im assistance with per	imum Data Set (MDS) dated R17 had diagnoses which depression, and end stage MDS identified R17 had pairment, required extensive sonal hygiene and was totally ities of daily living (ADL's) with ng.				
	3/27/22, identified F required as needed breath. A later note	rsing progress notes dated R17 had wheezing and inhalers for shortness of revealed R17 was placed on er respiratory symptoms.				
	R17 was noted to be eyes were closed, of her feet to upper chaminated eight (8)	ion on 3/28/22, at 4:48 p.m. e laying on her back in bed, covered with a blanket from lest. R17's door had a by 11 inch laminated sign 7 was on contact and droplet				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 12 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00679	B. WING		03/3	31/2022	
	PROVIDER OR SUPPLIER	ABILC 201 SHAD	DRESS, CITY, S DY LANE DR , MN 56482	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21390	precautions, and re wear and gloves we A further laminated was required for en container and a bed positioned outside of gloves, gowns, two grade masks and dinstructions of use.  During an observation R17 was seated in the room, had a we throat she was unaing room had contact a placed which identification worn. A four drawer bedside table were R17's room, which it types of N95 masks disinfecting wipes with the covered with a blue doorway continued contact and droplet an N95 was required plastic container and positioned outside of gloves, gowns, two grade masks and dinstructions of use.	vealed a mask, gown, eye ere required to enter the room. sign, identified an N95 mask try. A four drawer plastic did table were also of R17's room, which held a types of N95 masks, medical isinfecting wipes with  son on 3/29/22, at 10:21 a.m. a tilt in space wheelchair in to cough and congestion in her tole to clear. R17's door to her and droplet precautions signs fied an N95 was required to be plastic container and a also positioned outside of held a gloves, gowns, two son, medical grade masks and with instructions of use.  son on 3/29/22, at 2:38 p.m. to have signs, identifying precautions which identified to be worn. A four drawer did to be worn. A four drawer did a bedside table were also of R17's room, which held a types of N95 masks, medical isinfecting wipes with	21390				
	R17 was noted to b eyes were closed a from her feet to her assistant (NA)-E an	ion on 3/30/22, at 8:14 a.m. e laying in bed on her back, nd was covered with a blanket chin. At that time, nursing d NA-C, entered R17's room ssist R17 with morning cares					

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 13 of 23

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00679	B. WING			C <b>31/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	ABIIC	Y LANE DRI , MN 56482	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21390	NA-E had on eye promask, gloves and a eye protection, an Natisposable gown ar R17 with morning of at 8:38 a.m. licens entered R17's room N95 mask, gloves a proceeded to assist to a tilt in space chawith NA-E. NA-E regrade mask.  - at 8:42 a.m. NA-E regrade mask.  - at 8:42 a.m. NA-E gloves, gown, medith hand hygiene and of mask.  During an interview stated R17 was on precautions and incomplete for and was not able to weathere were none average for a several dozen N95 pull the third drawer another N95 pull the third drawer another N95 pull the N95 pull	rotection, a medical grade a disposable gown, NA-C wore N95 mask, gloves and a nd both proceeded to assist eares.  ed practical nurse (LPN)-C n, she wore eye protection, an and a disposable gown and transfer from her bed ear with a full mechanical lift mained wearing a medical area medical grade mask, completed donned a new medical grade on 3/30/22, at 8:43 a.m. NA-E contact and droplet dicated staff were to wear the earing her room; gown, gloves, an N95 mask. NA-E stated he ar an N95 into R17's room, as aliable. NA-E then moved to a container outside of R17's cond drawer open, revealed masks. NA-E proceeded to ropen, which revealed zen N95 masks. NA-E ot checked the drawers before	21390			

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 14 of 23

STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00679	B. WING		03/3	; 1/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/0	172022
	KS NURSING & REHA	ABIIC 201 SHAD	Y LANE DR	·		
	CLIMANA DV CTA		MN 56482	DDOV/DEDIC DLAN OF CODDECT	ONI	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ige 14	21390			
	vaccinated and another N95 if unvaccinated) after leaving R17's room.					
	LPN-B confirmed R precautions and state N95 mask when in did not notice what when R17's mornin indicated had she regrade mask on, she education and had During an interview facility infection prehad been placed or precautions due to tested negative for were required to we	on 3/30/22, at 1:05 p.m. R17 was on contact and droplet aff were required to wear an her room. LPN-B stated she type of mask NA-E had on ag cares were provided. She noticed NA-E had a medical e would have provided him to change to an N95.  on 3/31/22, at 8:37 a.m. the ventionist (IP) confirmed R17 in contact and droplet respiratory symptoms and had COVID-19. The IP stated staff ear an N95 in contact/droplet along with gowns, gloves, and				
	R249					
		ace sheet in the electronic d), revealed R249 was lity on 3/24/22.				
	EHR identified R24 the recommended	mmunizations record in the 9 was not up to date with all COVID-19 vaccine doses. as placed on Contact and s upon admission.				
	R249's room revea read "Contact and I signs indicated staf don (put on) eye pr	ion 3/29/22, at 11:12 a.m. of led signs on the door which Droplet Precautions." The if entering the room were to otection, N95 mask, isolation The supplies for the staff to				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 15 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING			С
		00679	B. WING		03/3	31/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	ABIIC	DY LANE DR A, MN 56482	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 15	21390			
	don prior to entering set of drawers outs	g the room were located in a ide the room.				
	nursing assistant (N	ion on 3/29/22, at 10:56 a.m., NA)-D entered R249's room, the bed in the room without a gown.				
	NA-D verbalized sh gown when entering	on 3/29/22, at 10:56 a.m., he should have been wearing a g the room and confirmed she n when she was in R249's				
	R245					
		ace sheet in the EHR, admitted to the facility on				
	EHR revealed R245 the recommended 6	mmunizations record in the 5 was not up to date with all COVID-19 vaccine doses. as placed on Contact and s upon admission.				
	R245's room had si "Contact and Drople indicated staff enter protection, N95 mas The supplies for the	ion on 3/28/22, at 4:45 p.m. igns on the door which read et Precautions." The signs ring the room were to don eye sk, isolation gown, and gloves. e staff to don prior to entering ted in a set of drawers outside				
	the Cook (C)-A was	ion on 3/29/22, at 12:11 p.m., s observed in R245's room ch tray while not wearing a				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 16 of 23

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00070	B. WING		00/0	
		00679	B. WING		03/3	1/2022
	PROVIDER OR SUPPLIER	201 SHAF	DRESS, CITY, S	STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	ABIIC	, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	During an interview director of nursing (observed C-A in R2 tray without wearing confirmed C-A shout to entering R245's non Contact and Drown Review of the facilit Transfers, and return during [the] COVID-identified upon admiresidents who were vaccinations would contact precautions. Review of the facilit Precautions revised transmission-based when transmission prevented by standadility was expected door or wall outside	on 3/29/22, at 12:12 p.m., the (DON) indicated she had (45's room serving the lunch gan isolation gown. The DON (14) and isolation gown. The DON (15) and isolation gown. The DON (16) are room due to the resident being oplet isolation.  By policy titled Admission, rn from Outings for Residents (19) and (19) are readmission and/or readmission and (19) are readmission and (19) are period of 10 days.  By policy titled Isolation (16) and (16) and (16) and (16) are readmission and the dopost clear signage on the ereof the resident room of precautions and required	21390			
	Catheter Care					
	3/3/22, identified R3 included dementia, amputations and obidentified R30 had sand required extens of daily living (ADL's hygiene and was to The MDS identified catheter.	imum Data Set (MDS) dated 30 had diagnoses which bilateral above the knee ostructive uropathy. The MDS severe cognitive impairment sive assistance with activities s) of dressing, personal tally dependent for bathing. R30 had an indwelling urinary				
	R30's current physi	cian orders revealed an order	1		l	

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 17 of 23

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00679	B. WING		03/3	; 1/2022
	PROVIDER OR SUPPLIER	ABILC 201 SHAD	DRESS, CITY, S DY LANE DR , MN 56482	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	for a supra pubic car connection between skin used to drain used to drain used to drain used to drain used to be flow), catheter care catheter is anchored physician orders late the catheter collect.  R30's current care R30 required a supsignificant urinary ruropathy. The care placement of R17's During an observat R30 was noted to be bed, his eyes were with a blanket from mid chest. R30's cafrom underneath the bed, and lead to a directly on a fall material at 6:49 p.m. R30's in bed on his back to be lowered to gracely on a fall material at 6:49 p.m. R30's in bed on his back to be lowered to gracely on a fall material at 6:49 p.m. R30's catheter collection on a fall mat on the During an observat R30 was noted to be a low bed. R30's excepted with a blank R30's catheter collection on the left signat on the floor.	atheter (surgically created in the urinary bladder and the urine from the bladder in struction of normal urinary every shift, cleanse tubing, divia Velcro or tape. R30's cked direction on placement of ion bag.  plan revised 3/24/22, revealed ra pubic catheter due to estention and obstructive plan lacked instructions for a catheter collection bag.  ion on 3/28/22, at 5:18 p.m. is laying on his back in low closed and he was covered his lower extremities to his atheter tubing was observed to blanket on the left side of his collection bag which laid it on the floor.  was observed to remain laying in a low bed (bed that is able bund level), his eyes were covered with a blanket. R30's bag remained laying directly	21390			

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 18 of 23

			X3) DATE SURVEY COMPLETED			
		00679	B. WING		03/3	31/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	ARILC 201 SHAD	Y LANE DR	IVE		
TAIN OA	INS NONSING & INCHIA	WADENA	, MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 18	21390			
	R30 was noted to be a low bed. R30's carobserved hanging of laying directly on a second with a chest. R30's cathet yellow urine, was covered with a chest. R30's cathet yellow urine, was of fall mat on the floor at 2:22 p.m. R30 verback in a low bed, it catheter collection is the floor on the left.	e laying in bed on his back, in theter collection bag was off the left side of his bed, fall mat on the floor.  was observed laying on his his eyes were closed and he blanket from his legs to his er collection bag, half full of observed laying directly on a his eyes were opened. R30's bag was observed laying on side of his bed, no urine was				
	mat on the floor.  During an interview stated R30 was tota which included dres bathing. NA-E indic received catheter of the collection bag wheelchair. NA-E w for R30's catheter of During an interview	on 3/30/22, at 2:23 p.m. NA-Eally dependent for all ADL's, using, personal hygiene and ated R30 had a catheter, ares twice daily and indicated as to be placed below R30's und or underneath R30's as unaware of any cover used collection bag.  on 3/30/22, at 2:40 p.m. urse (LPN)-A confirmed R30's				
	catheter collection I mat on R30's floor. R30's room, and to LPN-A opened the plastic catheter bag catheter collection I black bag and place left side of R30's be	bag was laying directly on a fall LPN- walked over to a chair in ok hold of a black plastic bag. bag which revealed a black holder, she then took R30's bag and placed it into the ed the catheter back on the ed. LPN-A stated she had r bag cover into R30's room a				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 19 of 23

STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00679	B. WING		03/3	; 1/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	172022
FAIR OA	KS NURSING & REHA	AB LLC	Y LANE DR MN 56482	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 19	21390			
	prevented the cathe completely off the f	indicated R30's low bed eter collection bag from being loor, however the cover was th infection control and for				
	infection prevention expect resident cat placed in a cover a possible. IP stated prevented the cathe however she expect	on 3/31/22, at 8:46 a.m. the hist (IP) stated she would heter collection bags to be nd kept off the floor if at all R30 had a low bed, which eter from being off the floor, sted the collection bag to be e possible infection control				
	A facility policy titled Management, revis bags would be cove	ed 11/4/20, identified catheter				
	director of nursing ( review and revise p to ensuring transmi followed. The direct could develop a syst develop a monitoring following guidance	THOD OF CORRECTION: The (DON) and/or designee could olicies and procedures related ssion based precautions were tor of nursing or designee stem to educate staff and ag system to ensure staff are with personal protection ntified transmission based				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one-				
21925	MN St. Statute 144 Residents of HC Fa	.651 Subd. 29 Patients & ac.Bill of Rights	21925			5/9/22
		ers and discharges. Residents ily transferred or discharged.				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 20 of 23

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00679	B. WING		03/3	5 1/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 03/3	1/2022
		201 SHAD	Y LANE DR			
FAIR U	AKS NURSING & REH	WADENA,	MN 56482			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21925	Residents must be proposed discharge justification no later discharge from the transfer to another notice shall include the proposed action telephone number of ombudsman pursua Act, section 307(a) of this right, may chnotice period ends. shortened in situatic control, such as a creview, the accommesidents, a change treatment program, resident's welfare, prohibited by the pupaying for the resident medical record. This MN Requirement by:  Based on interview to notify the State of facility transfer for creviewed for transfer.  Findings include:  Review of the R8's revealed R8 was ac 7/23/21, and readmed Review of R8's programmer.	notified, in writing, of the error transfer and its than 30 days before facility and seven days before room within the facility. This the resident's right to contest in, with the address and of the area nursing home and to the Older Americans (12). The resident, informed mose to relocate before the The notice period may be one outside the facility's determination by utilization modation of newly-admitted in the resident's medical or the resident's own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a caccommodate new residents from assignments.  The notice period may be one of two resident's medical or the resident's medical or the resident's own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a caccommodate new residents own assignments.  The notice period may be one of two residents of a caccommodate of the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a caccommodate new residents own assignments.  The notice period may be one of the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a caccommodate new residents own assignments.  The notice period may be one of the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities on a caccommodate new residents own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facility's determination of newly-admitted in the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in facility's determination of newly-admitted in the resident's medical or another or nonpayment for stay unless ablic program or programs ent's care, as documented in facility's determination of newly-admitted in the residen	21925	No POC required.		

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 21 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00679	B. WING		03/3	5 1/2022
	PROVIDER OR SUPPLIER  KS NURSING & REHA	ABILC 201 SHAD	DRESS, CITY, S DY LANE DR , MN 56482	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21925	arrived at the facility emergency room di-1/31/22, at 6:50 p.r. the hospital.  Review of the Omb month of January a no documentation to notified about R8's.  During an interview Social Service Direct process for notificating fax, at the beginning residents transferred facility during the process for notifical January 2022, and Ombudsman had bot transferred to the homogeneous discharged 2:50 p.m. and return on 1/31/22, at 6:40.  During an interview administrator stated were to fax the Omdischarged on a more sident had only be administrator confir discharge of R8 on communicated to the confirmation of the communicated to	y and transported R8 to the ue to R8's altered cognition. m. R8 had been re-admitted to udsman notifications for the nd February 2022, revealed he Ombudsman had been transfer to the hospital.  on 3/30/22, at 3:10 p.m., the ctor (SSD) indicated the tion of the Ombudsman was to go fthe month, a list of dor discharged from the revious month. SSD confirmed ations for the month of February 2022, revealed the een notified that R8 was ospital.  on 3/30/22, at 3:15 p.m., the (MDS) Coordinator confirmed from the facility on 1/30/22, at ned to the facility the next day, p.m.  on 3/30/22, at 3:20 p.m., the difference to the facility the next day, p.m. on 3/30/22, at 3:20 p.m., the difference of the expectation was staff budsman the list of residents on the passis even if the een gone for one day. The med the notification of the 1/30/22, had not been ne Ombudsman.	21925			
	Readmission, Bed I dated 1/04/19, reve	y policy titled Admission, Hold, and Transfer/Discharge aled a copy of the [discharge] to a representative of the				

Minnesota Department of Health

STATE FORM 6899 06P711 If continuation sheet 22 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7 11 15 1 27 11 1	or connection	is Entri 1971 Tent I tems Ent.	A. BUILDING:			
		00679	B. WING		03/3	) 1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR OA	KS NURSING & REHA	VB II C	Y LANE DR , MN 56482	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21925	Continued From pa	ge 22	21925			
	Office of the State I	Long-Term Care Ombudsman.				
	Director of Social S develop, review, an procedures to ensu notification of all ho The Director of Social Educate all appropriocedures.  The Director of Social Education of Social Educat	THOD OF CORRECTION: The services or designee could ad/or revise policies and are the ombudsman received espitalizations. Sial Services or designee could riate staff on the policies and sial Services or designee could systems to ensure ongoing R CORRECTION: Twenty-one				

Minnesota Department of Health

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

F5581031

(X2) MULTIPLE CONSTRUCTION

Printed: 04/15/2022 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF CORRECTION	IDENTIFICATION NUM		A. BUILDING	01 - DINING ADDITION 01	COMPL	
		245581		B. WING		03/2	29/2022
	ROVIDER OR SUPPLIER  KS NURSING & RE	HAB LLC	201 SH	RESS, CITY, STADY LANE		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	conducted by the M Public Safety, State 03/29/2022. At the Nursing & Rehab-B compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe Existing Health Car NFPA 99, the Health Fair Oaks Nursing four different times, dining building 02 with 1965 building all was determined to construction. It is safe walkway and a 2-horooms are in this building) with the 1965 building all was determined to construction. It is safe walkway and a 2-horooms are in this building) with the 1965 building was determined to be of the 1965 building of the 1965 building all was determined to be of the 1965 building of the 1965 building of the 1965 building of the 1965 building all was determined to be of the 1965 building of the 1965 buil	ty recertification survalinnesota Department Fire Marshal Division time of this survey, Fildg 01 was found in the requirements for paid at 42 CFR, Subpart from Fire, and the Fire Protection Associately Code (LSC), Clare and the 2012 edition has constructed to the control of Type IV(2HH) eparated by a 10-food our fire barrier. No skulding. The original by was constructed in 1 frype II (222) constructed II II (22	articipation art e 2012 ciation hapter 19 on of de. ucted at and e west of on that t enclosed eeping building 965, was auction,	K 000	DEFICIENCY)		
LABORATO	and has a wood roo 101 Sec 19.1.6.2. It constructed to the e is a 3-story building determined to be of and it has a wood ro 101 Sec 19.1.6.2. It constructed to the sign be of Type II(222) of surveyed as two building a dry pipe system as	of system that meets in 1972 a 3-story add east of the original but it in the property in the property is a 3-story add east of the original but it in the property is a 3-story add east of the property is a 3-story add east of the property is a 3-story add east of the property is a 3-story and east of the property is a 3-story in the fact of the property is a 3-story in the property in the property in the property is a 3-story in the property	NFPA dition was uilding that ruction, ts NFPA dition was mined to illity was cted with m. The dor	NATURF	TITLE		(XG) 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.

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

Printed: 04/15/2022 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - DINING ADDITION 01 COMPLETED 245581 B. WING \_ 03/29/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

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 RE OR LSC IDENTIFYING INFORMATION)		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	K 000				
K 000	Continued From page 1 system, in all areas open to the corridor, is common areas, and in all sleeping rooms on the facility's fire alarm system that has automatic fire department notification.  The facility has a capacity of 75 beds and census of 42 at the time of the survey.  The requirement at 42 CFR, Subpart 483 is MET.	in all s that are s	DEFICIENCY			
				n sheet Page 2		

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

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

F5581031

(X2) MULTIPLE CONSTRUCTION

Printed: 04/15/2022 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN	OF CORRECTION	IDENTIFICATION NUM	MBER:	A. BUILDING	02 - MAIN BUILDING 02	COMPL	ETED
		245581		B. WING		03/2	29/2022
	PROVIDER OR SUPPLIER	HAB LLC	201 SH	RESS, CITY, S ADY LANE IA, MN 564		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	conducted by the M Public Safety, State 03/29/2022. At the Nursing & Rehab-B compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe Existing Health Car NFPA 99, the Health Fair Oaks Nursing a four different times dining building 02 withe 1965 building at was determined to construction. It is safe walkway and a 2-ho	ty recertification survalinnesota Department Fire Marshal Division time of this survey, Foldg 02 was found in exequirements for paid at 42 CFR, Subparty from Fire, and the Fire Protection Associately Code (LSC), Clay and the 2012 edition to Care Facilities Code (Rehab was constructed to the condition of the constructed to the code is a 2-story addition of the constructed to the code is a 2-story addition of the	art of on on Fair Oaks articipation art e 2012 ciation hapter 19 on of de.  ucted at and e west of on that t enclosed eeping	K 000	DEFICIENCY)		
LABORATO	determined to be of and has a wood roo 101 Sec 19.1.6.2. It constructed to the eis a 3-story building determined to be of and has a wood roo 101 Sec 19.1.6.2. It constructed to the side of Type II(222) constructed as two building a dry pipe system a	letely sprinkler prote and a wet pipe syster detection in the corric	uction, NFPA ition was uilding that and was ruction NFPA dition was mined to illity was cted with m. The dor	NATURE	TITLE		(XG) 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.

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

Printed: 04/15/2022 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 02 - MAIN BUILDING 02 COMPLETED 245581 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 RE OR LSC IDENTIFYING INFORMATION)		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	K 000				
K 000	Continued From page 1 system, in all areas open to the corridor, is common areas, and in all sleeping rooms on the facility's fire alarm system that has automatic fire department notification.  The facility has a capacity of 75 beds and census of 42 at the time of the survey.  The requirement at 42 CFR, Subpart 483 is MET.	in all s that are s	DEFICIENCY			
				n sheet Page 2		