STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Nursing & Rehab LLC	201 Shady Lane Drive Wadena, MN 56482

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review the facility failed to ensure non-pressure related wounds were monitored for signs and symptoms of infection and healing until resolved for 3 of 3 residents (R1, R2, R3) reviewed. Findings include: R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 had a diagnosis of displaced comminuted fracture of shaft of right tibia and had a surgical wound. R1's April Medication Administration Record (MAR) revealed an order for monitor skin alteration/wound and document status of wound in progress notes every shift and identified R1's wound as right lower extremity, which was marked as completed by staff on the MAR every shift from 4/1/24 through 4/10/24, however R1's medical record lacked evidence of progress notes every shift on the status of R1's wound. R1's record did not identify any wound treatment orders for her right lower extremity. R1's Progress Note from Orthopedics appointment dated 4/3/24, indicated R1's right lower extremity incisions are clean, dry, and intact with nylon sutures. There was some mild serous drainage however did not look infectious. Dry dressings were placed over R1's incisions after removing her sutures and an ace wrap to help control swelling. However, there were no physician orders for any wound treatment for R1's right lower extremity following this appointment. R1's Weekly Skin Check dated 4/3/24, lacked a description or wound characteristics for R1's right lower extremity wound. Review of R1's Daily Skilled Charting revealed the following: - On 4/3/24, assessment identified R1 had a skin alteration, however, did not give any further detail on what R1's skin alteration was, where it was located, or any characteristics of the skin alteration. - On 4/4/24, assessment identified R1 had a skin alteration, however, did not give any further detail on what R1's skin alteration was, where it was located, or any characteristics of the skin alteration. (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 4/5/24, identified R1's right lower leg was in an ace wrap with a surgical boot on when out of bed. However, the assessment did not give any further detail on what R1's skin alteration was, where it was located, or any characteristics of the skin alteration. - On 4/6/24, assessment identified R1 had a skin alteration, however, did not give any further detail on what R1's skin alteration was, where it was located, or any characteristics of the skin alteration. - On 4/7/24, assessment indicated staff had changed dressing to R1's right lower leg, however the assessment did not give any further detail or characteristics of R1's wound. However, R1 did not have any treatment orders for dressings and R1's record lacked evidence following this note that the dressing was changed again. - On 4/8/24, indicated incisions on R1's right leg was clean and dry. R1's Discharge Summary/Recap of Stay dated 4/10/24, indicated R1 had a surgical wound and treatment for wound included covering with a dry bandage and keep clean and dry. In addition, licensed practical nurse (LPN)-A identified R1's wounds were noted to be clean and dry, however in an interview LPN-A confirmed she did not observe R1's wound on the day she discharged . R1's Progress Note from Urgent Care dated 4/11/24, indicated R1 presented to clinic for concerns of right leg surgical sire. R1 had recently been discharged from the facility to home on 4/10/24. On Sunday afternoon (4/7/24) the wound was looked at in the facility however, today (4/11/24) the home health nurse assessed the wound and there were concerns for infection. R1's wound was noticed to have redness and increased warmth and reports some yellowish liquid on bandage during dressing change. R1's incision site was noted to be dehisced and measured approximately 3 centimeters (cm) by 1.2 cm and did not track or probe. Further, R1's wound base was noted to have mixed granular and fibrotic tissue, scant amount of serosanguinous drainage present on dressing, and there were sutures and a steri-strip present to the site. R1 was diagnoses with cellulitis of right lower extremity and Keflex 500 mg oral capsule was ordered. On 4/16/24 at 11:57 a.m., home health registered nurse (RN)-A stated R1 had discharged from the facility on 4/10/24 and RN-A arrived at R1's home on 4/11/24, to complete an assessment. RN-A stated R1 did not have any wound treatment orders for her wound on her right lower extremity. RN-A stated upon completing her assessment, RN-A removed the gauze that was on R1's right lower extremity which was noted to be saturated and crusty with drainage with a very faint odor. Further, RN-A stated R1's right shin was red and hard and R1 expressed pain in the area when RN-A would touch her shin. RN-A recommended R1 be evaluated at the clinic for possible infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 9:32 a.m. licensed practical nurse (LPN)-A stated R1 admitted to the facility with a permanent cast on her right lower extremity and at her follow up orthopedic appointment the cast was removed and R1 was given a removable boot. LPN-A stated on R1's shower day LPN-A noted R1 had gauze over the wound with ace wrap, which LPN-A removed and then replaced with new gauze and ace wrap. LPN-A confirmed R1 did not have orders for any treatments to the wound, but LPN-A placed new gauze to prevent the ace wrap from pulling on the remaining sutures and that was what was on the wound prior. LPN-A stated she did not observe R1's wound the day of discharge as R1 had discharged earlier in the morning. Further, LPN-A stated observing a wound every day was important because day-to-day the wound could be different. In addition, LPN-A stated staff were expected to monitor wounds daily for signs of infection and each wound was assessed weekly by the wound team. During an interview with R1 and family member (FM)-A on 4/17/24 at 10:13 a.m., R1 stated she was discharged from the facility back to her home on 4/10/24. R1 was unsure if she had any orders for wound treatments but stated staff only looked at her lower extremity wound twice while at the facility. R1 stated the day after discharging the facility the home health nurse came and removed the old bandages from R1's lower extremity and was concerned. FM-A stated she was aware of an order for staff to monitor right lower extremity every shift and stated the order was not followed. R2's admission MDS dated [DATE], indicated R2 had diagnoses which included type 2 diabetes, spinal stenosis, and mild intellectual disability. Further, assessment revealed R2 had a surgical wound. R2's care plan revised on 4/8/24, indicated R2 had an alteration in skin integrity related to surgical wounds with staples on spine and iliac crest. R2 had a goal of skin integrity would show signs of improvement in healing and directed staff to administer treatments as ordered, apply barrier cream to affected sites as ordered, assess, and monitor the alteration and document weekly. Review of R2's treatment administration record (TAR) dated April 2024, lacked evidence of a nursing order to monitor for signs of infection or healing for R2's surgical wound on spine and iliac crest. Review of R2's Wound Evaluation dated 4/10/24, revealed spine and left iliac crest were evaluation and no signs or symptoms of infection were noted. During an observation on 4/16/24 at 2:24 p.m., R2 was sitting on the edge of her bed in her room. R2 stated she had an appointment last week where 26 staples in her lower back were removed. R2 lifted up the back of shirt, and revealed a long incision that appeared to be a little red around the edges and appeared to be scabbed over no signs of infection were noted. R3's admission MDS dated [DATE], indicated R3 had diagnoses which included neuropathy, heart failure and cognitively intact. Further assessment indicated R3 did not have any skin alterations. R3's care plan revised 4/8/24, indicated R3 was at risk for skin impairment and had actual alteration in skin integrity related to skin tear on right hand and open areas on coccyx. However, R3's care plan failed to identify actual skin impairment of left knee with stitches. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's TAR dated April 2024, directed staff to monitor wound/skin alteration every shift for evidence of pain and infection, update provider as needed, and document in progress notes if abnormal findings are noted. However, R3's order lacked staff direction of which wounds to monitor and failed to identify R3's left knee with stitches. R3's Wound Evaluation dated 4/10/24, did not identify where the wound was located but identified the wound to have sutures and no evidence of infection. During an observation on 4/16/24 at 1:46 p.m., R3 was sitting in her chair with her feet elevated in her room. R3 stated she had stitches in her left knee due to a fall she had prior to admitting to the facility. R3 pulls up pant leg to reveal the stitches which appeared to be intact and there was no redness, drainage or signs of infection noted. RN-B enters R3's room at 1:57 p.m. and states she was going to complete R3's wound treatment to a skin tear on her hand. RN-B stated she was unaware of R3's stitches on left leg and lifted up R3's pants to assess, and RN-B stated, let me go read the orders I am not sure if we need to do anything for those. RN-B returns to R3's room and stated there were no treatment orders, but stated there were six stitches and they looked good, no redness, warmth or drainage noted. On 4/16/24 at 2:32 p.m., RN-B stated upon admission to the facility a picture would be taken of a resident's surgical wound and uploaded into their record and the wound team would assess the wound weekly. RN-B stated licensed nurses were expected to monitor for signs and symptoms of infection daily which would be identified by a nursing order in the resident's record. RN-B stated she was not as familiar with R3 and typically was scheduled to work another unit, and RN-B stated R3's order should be more specific to direct staff to look at her left leg wound with the stitches because she was not aware they were there. On 4/16/24 at 2:48 p.m., RN-C stated R2 had her staples removed from her back last week and RN-C noted her skin to be red around the incision otherwise no signs of infection were noted. RN-C stated there were no treatment orders for her wound. RN-C stated R3 had sutures on the left knee that appeared to be clean, dry, and intact. RN-C stated R3's record lacked evidence of an order for staff to monitor those sutures so if staff did not typically work R3's unit they would not know the sutures were there. Further, RN-C stated R1 had her cast removed and her wound was then covered with gauze and ace wrap and staff direction to keep dry, but R1 did not have orders for the gauze and ace wrap only orders to monitor the wound for signs of an infection. In addition, RN-C stated upon admission to the facility staff would capture pictures of any wounds and upload them into the resident's record and the wound team would assess and determine treatment plan going forward. RN-C stated each resident who was identified to have a wound would have an order for monitoring in the record directing staff to visualize and observe for signs of infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 3:51 p.m., director of nursing (DON) stated R1 had a nursing order in her record that directed staff to monitor every shift and document in progress notes, however DON confirmed R1's record lacked evidence of documentation of wound in progress notes. DON stated R1's cast was removed on 4/3/24 and R1's sutures were removed then. DON confirmed there were no new treatment orders for R1's right lower extremity wound and there was no picture added under wounds, so DON is unsure if the wound was open or closed. Further, DON stated there was a note that indicated a wound dressing was applied, however R1 did not have any treatment orders. DON stated R2 had staples removed from her left iliac crest and back, however there was not a nursing order in R2's record for staff to monitor for signs of infection and pain until healed. DON stated R3 has sutures to left knee staff were expected to monitor for signs of infection until healed, however the monitoring order in R3's chart was not specific and did not indicate which wounds to monitor. In addition, DON stated staff were expected to monitor surgical wounds daily on every shift for signs of infection until healed which would be documented in the resident's record and monitoring would be added as a nursing order. On 4/17/24 at 12:13 p.m., RN-D stated she comes to the facility on Wednesday to complete wound assessments with the nurse practitioner. RN-D stated staff would be expected to monitor the wound daily to ensure no signs of infection or any sort of changes to the wound. Further, RN-D stated staff were not supposed to do any treatments without contacting a provider as staff were not allowed to make those decisions. RN-D stated if a wound bandage was not changed routinely the wound could become infected as stuff could sit under there and grow. In addition, RN-D stated if sutures or staples were removed from a wound it would still be important to continue to monitor the wound as the wound would not be completely healed yet. Review of facility policy titled Pressure Injury Prevention and Wound Care Management, indicated the purpose of the policy was to promote healing of existing wounds. Policy indicated skin impairments, which included surgical wounds, should be assessed weekly by the Wound Nurse or designee using the Wound Assessment. Further, policy directed the clinicians responsible for the care of the resident will assess daily the status of the dressing if present and evaluate for complications such as infection and/or uncontrolled pain.