

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2024
NAME OF PROVIDER OR SUPPLIER  Fair Oaks Nursing & Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083</b></p> <p>Based on observation, interview, and document review, the facility failed to monitor for healing and complete neuro checks for 1 of 3 residents (R1), who rolled off the bed and sustained a scalp hematoma and traumatic hematoma of forehead.</p> <p>Findings include:</p> <p>R1's annual Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included obstructive hydrocephalus (a neurological disorder caused by an abnormal buildup of cerebrospinal fluid in the ventricles (cavities) deep within the brain), morbid obesity, and epilepsy.</p> <p>R1's care plan revised on 3/21/22, indicated R1 had impaired mobility related to obstructive hydrocephalus, history of epilepsy, major depressive disorder, anxiety disorder, diabetes, morbid obesity, pain, muscle weakness, and inability to walk. Additionally, R1's Care Plan indicated she was at risk for bleeding and excessive bruising related to anticoagulant therapy related to immobility and sedentary lifestyle has history of deep vein thrombosis and embolism with interventions listed as: educate and remind resident to report any signs of bleeding or bruising to nurse, monitor for bruising bleeding with cares; monitor resident per MD orders; resident on anticoagulant therapy use caution with hands on assistance due to risk of bruising easily.</p> <p>Review of R1's Witnessed Fall report dated 7/7/24 at 12:50 p.m., indicated staff was called to resident's room reporting that resident had fallen out of bed. Staff was assisting with cares and had rolled resident onto her side towards the window when he realized he did not have wipes. Staff turned to grab some, letting go of resident who then fell between the bed and wall striking her head.</p> <p>R1's ED discharge report indicated she was seen for a right frontal forehead hematoma and occipital right scalp hematoma and anterior shoulder discomfort, range of motion tenderness located along the long head of biceps. CT findings revealed negative for acute intracranial hemorrhage or extra axial collection and hematoma X-ray of left shoulder was negative. R1 was discharged home with normal vital signs and without need for pain control.</p> <p>Diagnosis of: scalp hematoma and traumatic hematoma of forehead</p> <p>Discharge instructions:</p> <p>Ice can be used every 20 minutes 3-4 times per day to the area of affected swelling</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medication changes: None</p> <p>R1's Progress Notes revealed the following:</p> <p>-On 7/7/24 at 12:50 p.m., writer was called to resident's room that resident was on the floor. Resident had hit her head and had a large goose egg forming to the right side of forehead and to back of head. Resident kept stating it burns, it burns. Due to Warfarin use and hitting of head writer called 911 to have resident go in for evaluation.</p> <p>-On 7/7/24 at 4:55 p.m., R1 returned to the facility and was alert and responsive, bruising was noted to her right eye and forehead.</p> <p>-On 7/8/24 at 2:42 a.m., R1 vital signs were obtained. R1 was alert and neurology checks were intact. There was bruising noted to R1's right forehead and eye area with no increased swelling. R1 stated she was comfortable and R1's bed was in low position for safety.</p> <p>R1's progress notes lacked evidence of R1's bruising being monitored following the accident, as well ongoing neurological checks for the initial 72 hours post fall.</p> <p>R1's Order Summary Report dated 7/9/24, indicated R1 received Coumadin at bedtime related to personal history of venous thrombosis and embolism. Further, R1's orders lacked evidence of monitoring bruising from the accident and lacked evidence of neurological checks being completed.</p> <p>On 7/9/24 at 12:52 p.m., R1 was observed sitting in her wheelchair in the commons area. R1 appeared comfortable and appeared to be sleeping. R1 had notable bruising, various stages of healing and coloring, around both eyes and a large bump on the right side of her face/temple.</p> <p>On 7/9/24 at 2:04 p.m., nursing assist (NA)-A stated he was contracted through an outside staffing agency and had been working at the facility for approximately two weeks. NA-A stated R1 required staff assistance by two staff for all activities of daily living (ADLs) which included transfers, bed mobility, and incontinent care. NA-A stated on 7/7/24, he transferred R1 into her bed using the full mechanical lift, as required, following the noon meal with assistance by registered nurse (RN)-A. NA-A stated once R1 was in bed, RN-A left R1's room, and NA-A decided to assist R1 with incontinent cares. NA-A had rolled R1 onto her left side, and NA-A noted he did not have wipes available at R1's bedside. NA-A left R1 on her left side to grab wipes from the cabinet in R1's room, when R1 rolled off her bed, which was about level with the window, and fell on to the floor. NA-A stated he ran out of the room to grab the nurse.</p> <p>On 7/9/24 at 2:53 p.m., RN-A stated R1 returned from the emergency room later the same day with no new orders, and since the accident R1 had no changes in health condition and remained at her baseline. RN-A stated staff were expected to monitor any new bruising on resident every shift until resolved.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/10/24 at 11:21 a.m., RN-B stated staff were expected to monitor a resident's injuries every shift until resolved and a nursing order would be placed on the resident's treatment administration record (TAR). RN-B stated there was no monitoring for R1's bruising in her record. Further, RN-B stated neurological checks were expected to be obtained by staff following an unwitnessed fall or a fall with a head strike for three days, however RN-B stated she was unable to locate R1's neurological checks and was unsure if they were completed following R1's accident.</p> <p>On 7/10/24 at 12:09 p.m., director of nursing (DON) stated staff were expected to monitor a resident's injury until healed and would be added to the resident's treatment record, however DON confirmed she did not add a treatment order for staff to monitor R1's facial bruising following the accident. In addition, DON stated staff were expected to obtain neurological checks for 72 hours following a fall with a head strike however DON confirmed R1's neurological checks were unable to be located and stated staff would still be expected to be obtaining them as it had not been 72 hours since R1's accident.</p> <p>Review of facility policy titled Post Fall Policy revised 10/23/23, revealed staff would be expected to document on resident's condition at minimum of every shift for 72 hours which would include relevant post-fall findings such as vital signs, pain, bruising and changes in function as well as monitor for signs of head injury.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43083</p> <p>Based on observation, interview, and document review, the facility failed to follow plan of care for bed mobility and incontinence cares for 1 of 3 residents (R1) reviewed for accidents, when R1 rolled off the bed and sustained a scalp hematoma and traumatic hematoma of forehead and was sent to the emergency department (ED) for a CT scan with negative results.</p> <p>Findings include:</p> <p>R1's annual Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included obstructive hydrocephalus (a neurological disorder caused by an abnormal buildup of cerebrospinal fluid in the ventricles (cavities) deep within the brain), morbid obesity, and epilepsy.</p> <p>R1's care plan revised on 3/21/22, indicated R1 had impaired mobility related to obstructive hydrocephalus, history of epilepsy, major depressive disorder, anxiety disorder, diabetes, morbid obesity, pain, muscle weakness, and inability to walk. Further, R1's care plan identified R1 as Limited physical mobility with interventions listed as: does not ambulate; bed mobility assist of two, transfer full body lift assist of two, and large sling (do not use an amputee sling). FALL RISK identified as low risk she requires total assist of staff for significant movements, R1 has the potential for falls due to seizure disorder and staff error during positioning/transfers. Intervention identified as bed mobility is to be done by 2 staff at all times. Additionally, R1's Care Plan indicated she was at risk for bleeding and excessive bruising related to anticoagulant therapy related to immobility and sedentary lifestyle has history of deep vein thrombosis and embolism with interventions listed as: educate and remind resident to report any signs of bleeding or bruising to nurse, monitor for bruising bleeding with cares; monitor resident per MD orders; resident on anticoagulant therapy use caution with hands on assistance due to risk of bruising easily.</p> <p>Review of R1's Witnessed Fall report dated 7/7/24 at 12:50 p.m., indicated staff was called to resident's room reporting that resident had fallen out of bed. Staff was assisting with cares and had rolled resident onto her side towards the window when he realized he did not have wipes. Staff turned to grab some, letting go of resident who then fell between the bed and wall striking her head.</p> <p>R1's ED discharge report indicated she was seen for a right frontal forehead hematoma and occipital right scalp hematoma and anterior shoulder discomfort, range of motion tenderness located along the long head of biceps. CT findings revealed negative for acute intracranial hemorrhage or extra axial collection and hematoma X-ray of left shoulder was negative. R1 was discharged home with normal vital signs and without need for pain control.</p> <p>Diagnosis of: scalp hematoma and traumatic hematoma of forehead</p> <p>Discharge instructions:</p> <p>Ice can be used every 20 minutes 3-4 times per day to the area of affected swelling</p> <p>Medication changes: None</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Progress Notes revealed the following:</p> <p>-On 7/7/24 at 12:50 p.m., writer was called to resident's room that resident was on the floor. Resident had hit her head and had a large goose egg forming to the right side of forehead and to back of head. Resident kept stating it burns, it burns. Due to Warfarin use and hitting of head writer called 911 to have resident go in for evaluation.</p> <p>-On 7/7/24 at 4:55 p.m., R1 returned to the facility and was alert and responsive, bruising was noted to her right eye and forehead.</p> <p>-On 7/8/24 at 2:42 a.m., R1 vital signs were obtained. R1 was alert and neurology checks were intact. There was bruising noted to R1's right forehead and eye area with no increased swelling. R1 stated she was comfortable and R1's bed was in low position for safety.</p> <p>R1's Order Summary Report dated 7/9/24, indicated R1 received Coumadin at bedtime related to personal history of venous thrombosis and embolism.</p> <p>On 7/9/24 at 12:52 p.m., R1 was observed sitting in her wheelchair in the commons area. R1 appeared comfortable and appeared to be sleeping. R1 had notable bruising, various stages of healing and coloring, around both eyes and a large bump on the right side of her face/temple.</p> <p>On 7/9/24 at 2:04 p.m., nursing assist (NA)-A stated he was contracted through an outside staffing agency and had been working at the facility for approximately two weeks. NA-A stated R1 required staff assistance by two staff for all activities of daily living (ADLs) which included transfers, bed mobility, and incontinent care. NA-A stated on 7/7/24, he transferred R1 into her bed using the full mechanical lift, as required, following the noon meal with assistance by registered nurse (RN)-A. NA-A stated once R1 was in bed, RN-A left R1's room, and NA-A decided to assist R1 with incontinent cares. NA-A had rolled R1 onto her left side, and NA-A noted he did not have wipes available at R1's bedside. NA-A left R1 on her left side to grab wipes from the cabinet in R1's room, when R1 rolled off her bed, which was about level with the window, and fell on to the floor. NA-A stated he ran out of the room to grab the nurse.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/9/24 at 2:53 p.m., RN-A stated R1 required assist of two staff for all ADLs. RN-A stated just after noon meal, she assisted NA-A transfer R1 into her bed using a full mechanical lift. RN-A stated after the transfer NA-B entered R1's room and RN-A was walking out of R1's room, when RN-A overheard NA-B ask NA-A if he needed any assistance with R1, and NA-A declined NA-B's offer. RN-A stated she knew R1 required assistance of two staff but did not think about it at the time of the interaction and exited the room to continue her medication pass. RN-A stated she was then notified by NA-A shortly after the interaction that R1 was on the floor. RN-A stated NA-A reported to her he went to grab wipes and let go of R1 and R1 rolled out of bed and fell to the floor. RN-A stated upon arriving at R1's room she observed R1's bed was pushed out from the wall by the window, R1 was laying on her right side and RN-A noted a contusion or goose egg on R1's head. RN-A stated she was aware R1 was receiving a blood thinner, so RN-A called the emergency services to evaluate R1. Further, RN-A stated R1 returned from the emergency room later the same day with no new orders, and since the accident R1 had no changes in health condition and remained at her baseline. RN-A stated staff were expected to monitor any new bruising on resident's every shift until resolved. In addition, RN-A stated she provided immediate education to NA-A following the accident regarding importance of following each resident's care plan, however RN-A was unsure if all aids received training regarding following care plans since the accident.</p> <p>On 7/9/24 at 3:07 p.m., NA-C stated R1 required assist of two staff for ADLs such as transfers, bed mobility and incontinence cares. NA-C stated on 7/7/24, at approximately 12:30 p.m., she was on her break and upon return NA-C stated she was informed NA-A was assisting R1 by himself and R1 had fallen out of bed. Further, NA-C stated since the accident she had not received any education or training but stated the accident was a pretty big deal and she thought there should have been some education completed with all staff to prevent another accident.</p> <p>On 7/9/24 at 3:48 p.m., NA-D and NA-E confirmed there had been no recent education or training related to following care plans since R1's accident that they had received or read.</p> <p>On 7/10/24 at 9:59 a.m., licensed practical nurse (LPN)-A stated R1 required assist of two staff members for ADLs and LPN-A was aware R1 had an accident as evidenced by the bruising on her face however LPN-A was unsure of details related to the incident. LPN-A stated she had not received any education or training regarding following care plans since the accident.</p> <p>On 7/10/24 at 10:54 a.m., NA-B stated R1 was dependent on staff for all ADLS and required assistance of two staff for transfers and incontinence care. NA-B stated on 7/7/24 right after the noon meal, NA-B knew NA-A needed some assistance with R1 and as NA-B entered R1's room, RN-A was exiting. NA-B stated she had asked NA-A if anymore assistance was needed with R1's cares and NA-B declined NA-B's offer. NA-B stated she then continued to answer other resident's call lights when NA-A ran out of R1's room and stated R1 was on the floor. NA-B entered R1's room and observed R1 on the floor and R1 was stating it burns repeatedly, which NA-B indicated was a common phrase R1 would say when she was in pain. NA-B noted there was a bump on the front of R1's head and knew instantly R1 had a head injury so the emergency services was called. In addition, NA-B stated she had worked at the facility following the accident but stated she had not received any additional training or education regarding following care plans, and she was only directed to write a statement regarding the accident and nothing else since.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/10/24 at 12:09 p.m., director of nursing (DON) stated she was completing the investigation related to R1's fall that occurred on 7/7/24, and DON determined NA-A did not follow R1's care plan resulting in R1 falling off her bed. DON stated NA-A was immediately educated following the accident, but DON stated she was still working on completing an all-staff education related to following care plans. DON confirmed NA-B and RN-A had not been provided education or a disciplinary action related to R1's accident as they both knew R1 required assistance of two staff members for ADLs but did not assist NA-A.</p> <p>Review of facility policy titled Risk Management revised 10/13/23, defined accident as an unexpected, unintended event that causes a resident serious bodily injury such as a gross hematoma or head injury. Further, policy indicated the DON would review the incident report, statements from staff involved would be gathered and further investigation would be completed. Further, a root cause analysis would be completed, and recommendations would be made for preventative measures based on the root cause.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083</b></p> <p>Based on observation, interview, and document review, the facility failed to follow enhanced barrier precautions while providing high contact direct care for 1 of 2 (R1) residents reviewed.</p> <p>Findings include:</p> <p>R1's annual Minimal Data Set (MDS) dated [DATE], indicated R1 had a diagnosis of extended spectrum beta lactamase (EBSL) resistance (enzymes that confer resistance to most beta-lactam antibiotics, including penicillin, cephalosporins, and the monobactam aztreonam).</p> <p>R1's care plan revised on 3/21/22, indicated R1 had impaired mobility related to obstructive hydrocephalus, history of epilepsy, major depressive disorder, anxiety disorder, diabetes, morbid obesity, pain, muscle weakness, and inability to walk. Further, R1's care plan identified R1 required assist of two staff for bed mobility and toileting. However, R1's care plan lacked evidence of R1 requiring enhanced barrier precautions.</p> <p>On 7/9/24 at 12:56 p.m., R1's door was closed with a sign posted outside of the door indicating R1 required enhanced barrier precautions and directed staff to wear gloves and a gown for the following high contact resident care activities: dressing, transferring, changing linens, providing hygiene, or changing briefs. Upon entering R1's room, nursing assistant (NA)-F and NA-G were transferring R1 into bed using a full mechanical lift. NA-F and NA-G removed lift sheet from under R1, removed R1's socks and began removing R1's incontinent brief. When questioned regarding signs posted outside of R1's door, NA-F and NA-G stated R1 was not on enhanced barrier precautions and stated that was for resident's who had a wound, an infection, or a catheter, and R1 did not have any of those things. NA-F and NA-G continued to provide incontinence care and hygiene without personal protective equipment (PPE) on. At approximately 1:04 p.m., NA-F and NA-F exit R1's room.</p> <p>On 7/9/24 at 1:05 p.m., director of nursing (DON) confirmed R1 was on enhanced barrier precautions due to a diagnosis of EBSL and staff were expected to wear PPE as directed.</p> <p>Review of facility policy titled Enhanced Barrier Precautions (EBP) dated 3/26/24, indicated EBP would be implemented during high-contact resident care activities when caring for residents that had an increased risk for acquiring a multidrug-resistant organism (MDRO). EBP will not only focus on resident with infection or colonization with MDRO's but will also address resident at risk for developing or becoming colonized. Additional MRDOs that are epidemiologically important to include was ESBL. Further policy indicated facility would post clear signage on the door/wall outside the resident's room and for resident for whom EBP are indicated, EBP would be employed when performing the following high-contact resident care activities: dressing, transferring, providing hygiene, changing linens, and changing briefs. In addition, policy stated communication and education would be provided to all staff caring for or entering resident room for directions.</p>		