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	08/15/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review, the facility failed to ensure adequate supervision was provided for 1 of 3 residents (R2) reviewed, who required supervision while eating due to assessed choking risk. Findings include: R2's admission Minimal Data Set (MDS) dated [DATE], indicated R2's diagnoses included epilepsy, hemiplegia and hemiparesis following cerebrovascular disease, and no cognitive impairment. Further, MDS revealed R2 did not have any swallowing concerns but was assessed to require a mechanically altered diet. R2's care plan dated 5/30/24, indicated R2 had potential for altered nutritional status and required Level 6 Soft and Bite Sized diet texture, and R2 was independent with eating however required to eat in the dining room as she needed to be supervised. R2's Risks vs Benefits document dated 6/26/24, indicated R2 had a risk of having swallowing issues related to diagnosis of hemiplegia and hemiparesis. R2 had minimal teeth that made it hard to properly chew food all the way. During continuous observation from 11:59 a.m. until 12:25 p.m., on 8/14/24, R2 was observed sitting in her standard wheelchair in a commons area room by the nursing station, at a table with another female resident. R2 appeared to be eating independently and there were no staff within vision of R2. There were two nursing assistants (NAs) in the day room assisting other residents with their noon meal and licensed practical nurse (LPN)-A joined the residents in the day room as well, and R2 was not within visual sight of the staff. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 12:33 p.m., LPN-A stated a resident who would require supervision while eating would be identified in the resident's care plan and the staff on the unit typically work on this floor so all the staff were aware of who required supervision. LPN-A stated R2's cognition was severely impaired and was on a mechanically altered diet due to her teeth and required supervision during meals for encouragement to eat. LPN-A stated R2 had no history of choking or concerns related to swallowing. Further, LPN-A stated staff determined to separate R2 from the other residents in the day room during meals due to R2's increased behaviors. When questioned about R2's care plan which identified R2 required supervision, LPN-A stated, that needs to be changed and staff watch her, we come out and check on her every couple minutes, we take turns. On 8/14/24 at 1:06 p.m., dietary manager (DM) stated she would expect residents who required an altered diet consistency, which included Level 6, to be supervised while eating and were encouraged to eat in the dining room. On 8/14/24 at 3:21 p.m., NA-A stated if a resident required supervision during meals, it would be identified in their care plan. NA-A stated R2 had impaired cognition and required staff supervision while eating due to being at risk for choking. On 8/15/24 at 10:55 a.m., registered nurse (RN)-A stated R2 had impaired cognition and required supervision while eating as she was on a soft and bite sized diet. RN-A stated R2 has had no incidents of choking. On 8/15/24 at 11:49 a.m., director of nursing (DON) stated R2's had impaired cognition and poor safety awareness. DON stated she was on a Level 6 diet and required supervision while eating for safety reasons, however DON stated R2 had no history of choking or aspiration since admitting to the facility. Further, DON stated R2 was moved to a different unit and then, due to behaviors, was moved to a smaller area away from another resident in the dining room to create a good dining experience. DON added due to the move, R2's supervision during meals got lost or forgotten and staff would be expected to refer to each resident's care plan for supervision needs. Review of facility policy titled Diet and Diet Orders revised 12/11/23, lacked evidence of staff direction on when residents require supervision while eating.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review, the facility failed to ensure the residents received the prescribed diet, as ordered, for 1 of 2 residents (R2) reviewed for mechanically altered diets. Findings include: R2's admission Minimal Data Set (MDS) dated [DATE], indicated R2's diagnoses included epilepsy, hemiplegia and hemiparesis following cerebrovascular disease, and R2 had no cognitive impairment. Further, MDS revealed R2 did not have any swallowing concerns but required a mechanically altered diet. R2's Order Summary Report dated 8/14/24, indicated R2 required a regular diet, level 6 soft and bite sized texture, thin liquid consistency and directed staff to add fluid to foods and add salt to foods as or 5/29/24. Review of International Dysphasia Diet Standardization Initiative (IDDSI) dated 01/19, indicated Level 6 Soft and Bite-Sized for adults consisted of soft, tender and moist, ability to bite off a piece of food is not required, ability to chew bite sized pieces so that they are safe to swallow is required, pieces no bigger than 1.5 cm by 1.5 cm in size, food can be mashed or broken down with pressure from fork. Further, Level 6- Soft and Bite-Sized food may be used if the individual was not able to bite off pieces of food safely but are able to chew bite-sized pieces down into little pieces that are safe to swallow and pieces that are bite-sized to reduce choking risk. In addition, IDDSI indicated food textures to avoid due to choking risk for adults who need Level 6 Soft and Bite-Sized food included foods with husks such as corn. During continuous observation from 11:59 a.m. until 12:25 p.m., on 8/14/24, R2 was observed sitting in her standard wheelchair in a commons area room by the nursing station, at a table with another female resident. R2 appeared to be eating independently and there were no staff within vision of R2. There were two nursing assistants (NAs) in the day room assisting other residents with their noon meal and licensed practical nurse (LPN)-A joined the residents in the day room as well, and R2 was not within visual sight of the staff. R2 was observed to have regular corn on her plate that appeared to be eaten. On 8/14/24 at 12:33 p.m., licensed practical nurse (LPN)-A stated R2 required a mechanical diet but was unsure for certain and stated R2 would be able to eat regular corn with her prescribed diet. LPN-A stated R2 has no history of choking or swallowing concerns that she was aware of. At 12:37 p.m., LPN-A was standing next to R2 while R2 was eating and did not remove R2's plate with incorrect diet. On 8/14/24 at 12:59 p.m., dietary manager (DM)-A stated R2 was assessed upon admission and determined to require a Level 6 Soft and Bite- Sized texture diet due to some difficulty she was having with foods. DM-A stated R2's diet would require creamed corn rather than regular corn. DM-A requested dietary aide (DA)-A to go remove R2's tray. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 1:05 p.m., DA-A entered the unit to remove R2's tray, and R2 was no longer at the table eating. DA-A stated R2 required Level 6 Soft and Bite-Sized texture foods which meant the food was required to be cut and a fork could cut through the food with ease. DA-A stated she was the cook that day and she would have been the staff that would have dished up R2's noon meal. DA-A stated each resident has a dietary slip on the tray the cook would review and determine which food the resident would get for their meal, and the plate was then delivered by the dietary aides who should also be verifying on the meal ticket that it is the correct resident and correct diet prior to serving the plate to the resident. In addition, DA-A stated she reviewed R1's dietary slip prior to dishing up the plate however stated, I spaced it honestly and R2 should have received the creamed corn instead of regular. DA-A confirmed R2 had ate some of the regular corn. On 8/14/24 at 1:06 p.m. DM-A stated the facility process to ensure residents receive the correct prescribed diet consisted of DM-A creating a pink slip of paper for each resident's tray that would identify diet order, fluid restrictions, or allergies that would draw attention for the dietary staff. DM-A stated the cook would be expected to review the slip of paper to ensure the resident received the proper diet and the aid delivering the resident's meal tray would verify the tray was for the correct resident containing the correct diet. On 8/15/24 at 11:49 a.m., director of nursing (DON) stated R2's had impaired cognition and poor safety awareness. DON stated she was on a Level 6 diet and required supervision while eating for safety reasons, however DON stated R2 had no history of choking or aspiration since admitting to the facility. Further, DON stated staff were expected to verify with each resident's tray card, which included the resident's prescribed diet, prior to giving the resident the meal tray. Review of facility policy titled Diet and Diet Orders revised 12/11/23, indicated the facility would utilize a tray identification system to ensure diet accuracy in the service of the meals. Further, policy directed food service director or dietary manager would ensure that food provided was consistent with diet order and that the tray card accurately reflects resident diet order and food preferences. Review of facility policy titled Hospitality and Dining Services dated 1/1/20, stated tray line and set up procedures were planned for an efficient and orderly delivering system and all meal orders were checking by dining service personnel for accuracy. Further, policy indicated meal orders were also checked by staff serving the meal before giving it to the individual. Policy also indicated each meal staff would be expected to check for: correct individual name, dining area and diet order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene was performed while assisting with toileting cares for 1 of 1 residents (R3) reviewed. Findings include: R3's significant change Minimal Data Set (MDS) dated [DATE], indicated R3 had diagnoses which included fusion of spine and reflex neuropathic bladder. R3's care plan dated 8/2/24, indicated R3 required assist of one staff for toileting and personal hygiene needs. On 8/14/24 at 2:39 p.m., nursing assistant (NA)-B and NA-C knocked and entered R3's room. R3 was sitting on the commode and was hooked up to the mechanical sit to stand lift. NA-B and NA-C applied gloves, NA-C got out wipes and assisted R3 with toileting hygiene cares. NA-C tossed the wipes into the garbage can and NA-B assisted with pulling up R3's brief and pants. NA-C continued to wear the same gloves and grabs R3's wheelchair, touched the mechanical lift, grabbed the garbage, and touched the doorknob. NA-C was stopped by surveyor prior to exiting the room with the same gloves on, and NA-C removed the gloves. On 8/14/24 at 3:08 p.m., NA-C stated staff would be expected to remove soiled gloves after every task and change gloves between different cares. NA-C confirmed changing gloves when going from dirty to clean would be expected as well as performing hand hygiene. On 8/15/24 at 11:49 a.m., director of nursing (DON) stated staff would be expected to remove their gloves after assisting with peri care as the gloves would be considered soiled, perform hand hygiene, and apply new gloves to continue with cares as needed. Review of facility policy title Hand Hygiene revised 5/8/24, indicated staff will perform hand hygiene before applying gloves and after removing gloves, after contact with body fluids, and after providing direct resident care. Further, policy directed staff to perform hand hygiene before moving from a contaminated body site to a clean body site during resident care, for example, after providing peri-care, before applying moisture barrier or other treatments.