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	01/14/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 1 of 3 residents (R1) who had unwanted facial hair present, reviewed for dignity. Findings Include: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact, and had diagnoses which included: hypertension, diabetes mellitus, respiratory failure, and fracture in past six months. Indicated R1 was dependent on staff for transfers, dressing and personal hygiene, which included shaving. R1's Care Area Assessment (CAA) dated 12/20/24, identified R1 had an activities of daily living (ADL) self-care performance deficit related to (r/t) collapsed vertebra, and was working with therapy. Indicated R1's care plan for self-care deficit and impaired physical mobility would be completed. Staff would assist with ADL completion and encourage self-participation. R1's care plan revised 12/30/24, identified R1 had an ADL self-care performance deficit related to collapsed vertebra. R1's interventions included personal hygiene assist of one staff. Review of R1's progress notes from 12/10/24 to 1/13/25, lacked documentation R1 refused to have facial hair removed. During an observation and interview on 1/13/25 at 10:46 a.m., R1 was in his room in a recliner, dressed in street clothes, and family member (FM)-A was present. R1 had a large amount of white facial hair on chin approximately one fourth inch long. R1 indicated it bothered her and staff were to assist her with removing the facial hair. R1 stated staff had not offered to remove her facial hair and she wanted it removed. During an interview on 1/13/25 at 11:06 a.m., nursing assistant (NA)-A, indicated she had not taken care of R1 for a few days, however would have removed R1's facial hair if it was present and visible. At 11:23 a.m. NA-A entered R1's room then after leaving R1's room, confirmed R1 had a large amount of facial hair present and indicated R1 should have been shaven. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/13/25 at 11:38 a.m., R1 was in recliner in her room, and facial hair had been removed. R1 rubbed her chin and indicated NA-A had removed her facial hair, which was really nice and she felt better. During an interview on 1/13/25 at 2:42 p.m., licensed practical nurse (LPN)-A stated she was aware R1 needed to have facial hair removed. LPN-A indicated FM-A was going to bring in a new razor for R1, and was unaware if the facility had razors they could use if residents did not have their own. LPN-A stated she expected staff to assist with removing facial hair when observed, had also assisted residents with removing facial hair, and had shaven R1 herself in the past. LPN-A was not aware R1 had ever refused to have facial hair removed. During an interview on 1/13/25 at 3:24 p.m,, director of nursing (DON) confirmed R1 was cognitive and was able to express her needs. DON indicated her expectation was that staff would assist residents to remove unwanted facial hair as it was important for maintaining a resident's dignity. The facility policy titled Activities Of Daily Living (ADLs) dated 3/15/21, identified based on comprehensive assessment of a resident and consistent with the residents's needs and choices, the facility would provide the necessary care and services to ensure that a resident's abilities in activities of daily living did not diminish unless circumstances of the individual's clinical condition demonstrated that such diminution was unavoidable. The policy identified the facility would provide care and services for the following ADLs, which included: hygiene-bathing, dressing, grooming, and oral care. ADL cares would be provided based on the resident preferences. If the resident refused care, that would be reported to the nurse and the resident re-approached. Documention of refusal would be completed in the electronic medical record. The facility policy titled Resident Rights: Dignity revised 10/24/23, identified the facility would treat each resident with respect and dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility would protect and promote the rights of the residents. The policy further identified federal and state laws guaranteed certain basic rights to all residents of the facility and these rights included the resident's right to a dignified existence, and to be treated with respect, kindness, and dignity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on interview, and document review, the facility failed to ensure an allegation of employee to resident abuse was immediately reported no later than two hours, to the State agency (SA) for 1 of 3 residents (R4) reviewed for abuse. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had severe cognitive impairment and diagnoses which included: Alzheimer's disease, anxiety and depression. R4's MDS indicated R4 had no behaviors and was dependent on staff for transfers, eating, dressing and personal hygiene. R4's Care Area Assessment (CAA) dated 9/30/24, identified R4 had severe cognitive impairment and was unable to follow a conversation and answer appropriately. R4 had signs of short term memory, and was unable to recall what a daily object was such as a shirt, television, bed or colors. R4 attempted to hit staff while they were doing cares. Staff were unable to redirect R4 when R4 had these behaviors. R4's care plan revised 1/2/25, identified R4 had an activities of daily living (ADL) self-care performance deficit and limited physical mobility with interventions which included: assistance for bathing/showering, dressing, personal hygiene toilet use, and transfers with two staff and a Hoyer (mechanical) lift. Indicated R4 had impaired cognitive function, and vulnerability of self and or others related to cognitive impairments/dementia, decreased cognition, medical condition/situation. Interventions included to provide safe environment and remove R4 from potentially abusive situations. During an interview on 1/14/25 at 9:39 a.m., NA-C indicated R4 was usually pretty quite, sang a lot and required total assistance with cares. NA-C stated at times R4 could be a little resistive to cares, and R4 was not fond of her oxygen and would push staff away. NA-C indicated she had reported an allegation of employee to resident abuse to human resources director (HR)-A back in June, 2024. NA-C indicated she had reported that trained medication aide (TMA)-A said R4 swatted at her, and she heard TMA-A tell R4 don't you hit me, do you want me to hit you?. NA-C stated she felt that was emotionally abusive towards R4, so she reported it to HR-A. NA-C stated she was unaware if anything was done about it, as TMA-A worked the next day. During an interview on 1/14/25, at 9:56 a.m., HR-A stated the allegation of abuse NA-C had reported sounded vaguely familiar, however could not remember the details or circumstances. HR-A stated her usual process if allegations were reported to her, was to notify the staff member's supervisor, director of nursing (DON) or administrator. HR-A indicated it may have been documented in TMA-A's employee file. HR-A opened TMA-A's file and produced a copy of TMA-A's Employee Counseling Record dated 6/28/24. Review of TMA-A's Employee Counseling Record dated 6/28/24, included the following: -type of notice: coaching and verbal warning were identified by their boxes checked. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-detail of description of the problem: It was alleged that staff member yelled at resident, Do you want me to hit you? -detailed description of corrective action: When addressing residents staff members must not be verbally abusive. Federal and state law guarantee that certain basic rights to all residents of this facility. You are expected to do [NAME] Essentials Part 1, due by the end of today, June 28, 2024. -Form signed by employee, DON and HR-A. During a telephone interview on 1/14/25 at 11:18 a.m., TMA-A indicated she remembered the incident in June, 2024. TMA-A stated residents would hit out when they least expected it, so TMA-A attempted to teach residents if they had dementia just like they would teach children. TMA-A indicated she had received dementia training, and confirmed teaching residents with dementia like children was not part of the training, just something she had picked up over the years. TMA-A stated DON had spoken to her about the incident, and told her she should not say those things, as a family member could be close by and could hear her. TMA-A indicated she was not trying to be mean, just was trying to teach R4. TMA-A said she was written up for the incident. During an interview on 1/14/25 at 12:10 p.m., DON indicated the allegation of abuse made on 6/28/24, could have been considered abusive, however the prior administrator was made aware and they decided it was not an act of abuse. DON confirmed the allegation of abuse was not reported to the SA, and it was important to report allegations of abuse to the SA to help keep residents safe. DON stated the facility did not condone abuse, so if it was suspected, it should have been reported. The facility policy titled Vulnerable Adult Abuse And Neglect Prevention revised 10/29/24, identified the purpose was to provide residents a safe environment free from harm. The policy identified all allegations and/or suspicions of abuse must be reported to the Administrator immediately, and if the administrator was not present, the report would be made to the administrator's designee. The facility must report to the SA immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on interview and document review, the facility failed to submit to the State Agency (SA) the results of the investigation within 5 working days for 1 of 3 residents (R4) reviewed for abuse, for 1 of 1 allegations of abuse reviewed. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had severe cognitive impairment and diagnoses which included: Alzheimer's disease, anxiety and depression. Indicated R4 had no behaviors and was dependent on staff for transfers, eating, dressing and personal hygiene. R4's Care Area Assessment (CAA) dated 9/30/24, identified R4 had severe cognitive impairment and was unable to follow a conversation and answer appropriately. R4 had signs of short term memory, and was unable to recall what a daily object was such as a shirt, television, bed or colors. R4 attempted to hit staff while they were completing cares. Staff were unable to redirect R4 when R4 had these behaviors. R4's care plan revised 1/2/25, identified R4 had an activities of daily living (ADL) self-care performance deficit and limited physical mobility with interventions which included: assistance for bathing/showering, dressing, personal hygiene, toilet use, and transfers with two staff and a Hoyer (mechanical) lift. Indicated R4 had impaired cognitive function, and vulnerability of self and or others related to cognitive impairments/dementia, decreased cognition, medical condition/situation. Interventions included to provide safe environment and remove R4 from potentially abusive situations. During an interview on 1/14/25 at 9:39 a.m., NA-C indicated R4 was usually pretty quiet, sang a lot and required total assistance with cares. NA-C stated at times, R4 could become a little resistive to cares. NA-C stated she had reported an allegation of employee to resident abuse to human resource director (HR)-A back in June 2024. NA-C indicated she had reported that trained medication aide (TMA)-A said R4 swatted at her, and she heard TMA-A tell R4 don't you hit me, do you want me to hit you? NA-C stated she felt that was emotionally abusive towards R4, and she reported it to HR-A. NA-C stated she was unaware if anything had been done about it, as TMA-A worked the next day. During an interview on 1/14/25, at 9:56 a.m., HR-A stated the allegation of abuse NA-C had reported sounded vaguely familiar, however could not remember the details or circumstances. HR-A stated her usual process when allegations were reported to her, was to notify the staff member's supervisor, director of nursing (DON) or administrator. HR-A indicated it may have been documented in TMA-A's employee file. HR-A opened TMA-A's file and produced a copy of TMA-A's Employee Counseling Record dated 6/28/24. Review of TMA-A's Employee Counseling Record dated 6/28/24, included the following: -type of notice: coaching and verbal warning were identified by their boxes checked. -detail of description of the problem: It was alleged that staff member yelled at resident, Do you want me to hit you? (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-detailed description of corrective action: When addressing residents staff members must not be verbally abusive. Federal and state law guarantee that certain basic rights to all residents of this facility. You are expected to do [NAME] Essentials Part 1, due by the end of today, June 28, 2024. -Form signed by employee, DON and HR-A. During an interview on 1/14/25 at 12:10 p.m., DON indicated the allegation of abuse made on 6/28/24, could have been considered abusive, stated the prior administrator was aware and they decided it was not abuse. DON indicated it was important to investigate allegations of abuse to keep residents safe. DON indicated she thought there was a thorough investigation completed by the previous administrator, and thought he would have kept that. DON indicated she would look for the documention and provide it to surveyor when found. DON confirmed the investigation of the abuse allegation had not been submitted to the SA. Review of the untitled investigation report dated 6/28/24, included a summary of the allegation and findings, interviews with TMA-A, other staff members and residents. The investigation contained a copy of TMA-A's Employee Counseling Record dated 6/28/24, and a staff sign in sheet for education on Abuse Policy Training dated 7/2/24. The facility policy titled Vulnerable Adult Abuse And Neglect Prevention revised 10/29/24, identified it's purpose was to provide residents a safe environment free from harm. The policy identified upon receiving a complaint of alleged maltreatment, the Administrator would be notified immediately, and they, DON or assigned designee, would coordinate an investigation, which would include completion of witness statements-staff, residents or visitors who were potentially involved, or observed the alleged incident were to interviewed by the DON, director of social services, or their designees. All parties involved including two of the following. When a specific staff member was implicated in the alleged event, the person would be removed from the residents care area immediately, interviewed by the supervisor assigned, and asked to provide a written statement and suspend until the investigation was completed. The policy further identified within five business days, an investigation report would be completed and turned in to the department of health and to the facility administrator or designee. The report woud include details of facility investigation which included a summary of information obtained from interviews of residents, staff and witnesses as appropriate, how had the resident's ability and lifestyle been affected, details of the alleged perpetrator and any action that had been taken to prevent the recurrence of the incident.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview, and document review, the facility failed to ensure a resident call light was within reach for 1 of 4 residents (R3) reviewed for call light accessibility. Findings Include: R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 was cognitively intact, and had diagnoses which include: anxiety, depression, and asthma (a condition that affects airways and makes breathing difficult). Indicated R3 was dependent on staff for rolling left and right, transfers, dressing and hygiene. R3's Care Area Assessment (CAA) dated 8/23/24, identified R3 had chronic pain related to low back pain, neuropathy (condition that affects the nerves outside brain and spinal cord) and history of fusion of lumbosacral region (surgical joining of vertebrae to the lower back area of spine). R3 took Lyrica (medication used to treat nerve pain) for pain management. R3's care plan revised 10/3/24, identified R3 had an activities of daily living (ADL) self-care performance deficit and limited physical mobility related to fusion of lumbosacral region of the spine, low back pain, neuropathy, abnormalities of gait and mobility, weakness and deconditioning. R3's inventions included: dressing, personal hygiene and bathing assistance of one. Interventions included bed mobility assistance of one, and transfer assistance of two with stand up lift. Identified R3 had chronic pain and the potential for shortness of breath (SOB) while lying flat related to Asthma diagnosis. During an observation on 1/14/25 at 7:53 a.m., R3 was lying in bed, on her right side facing the wall, door open, and lights off. R3 called out, and when surveyor entered the room, R3 stated could not move and wanted to be moved. R3 then indicated was unable to locate her call light. R3's call light was clipped to its cord, attached to the wall, behind the head of R3's bed, out of reach. Surveyor located nursing assistant (NA)-B, who then entered R3's room. NA-B stated she was not sure why R3's call light was attached to the wall, then R3 informed NA-B the night shift had put it up there. R3 informed NA-B she could not breath, wanted to be turned and indicated her hips and thighs were causing her pain. R3's face was red in color. NA-B called on walkie talkie for staff assistance and trained medication aide (TMA)-B entered the room. TMA-B asked R3 how she was and R3 stated she could not breath. TMA-B called for a nurse on her walkie talkie, [NAME] and TMA-B assisted R3 to reposition to her back, boosted her up in bed, and elevated her head of bed. R3 indicated she felt better, R3's color improved and was pink at that time. During an interview on 1/14/25 at 9:09 a.m.,NA-B stated she was shocked R3's call light was attached to the wall and not placed within her reach. NA-B indicated she felt terrible about that and said at 6:15 a.m. they had made rounds, observed R3 asleep in her bed and did not see where the call light was positioned. NA-B indicated it was important for residents to have their call light so they could call for assistance when needed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/14/25 at 9:25 a.m., R3 indicated staff sometimes clipped her call light to the wall. R3 stated it caused her trouble that morning, and she thought she had waited about two hours for assistance due to not being able to use the call light. During an interview on 1/14/25 at 10:57 a.m., licensed practical nurse (LPN)-B indicated R3 was able to inform staff what she wanted and her memory was usually intact. LPN-B stated NA-B had informed her that R3 did not have her call light that morning. LPN-B stated it was important to have the call light within reach so the residents could use the call light to alert staff when they needed assistance. During an interview on 1/14/25 at 12:05 p.m., director of nursing (DON) stated her expectation was that residents had their call lights within reach at all times. DON indicated staff were expected to check call lights to assure they were within reach when they made their rounds. DON stated it was important for residents to have their call light, for resident safety and dignity. The facility policy titled Call Light Use And Response revised 7/18/23, identified its purpose to respond promptly to resident's call for assistance and to assure call system was in proper working order. The policy identified that staff would position the call light conveniently for the resident and within easy access for use when providing care to the residents. The policy indicated staff were to be sure call lights were placed with reach at all times.