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 06/27/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49014 Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 1 resident (R34) who was observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings include: R34's admission Minimum Data Set (MDS) dated [DATE], identified R34 had moderate cognitive impairment and had diagnosis which included acute respiratory failure, Chronic obstructive pulmonary disease (COPD), (a chronic inflammatory lung disease that causes obstructed airflow from the lungs, and hypertension (elevated blood pressure). R34's care plan identified R34 had an activity of daily living (ADL) self-care performance deficit related to immobility and weakness. R34's care plan interventions included dependence on staff for bathing, dressing, and toileting. Identified R34 had a double below the knee amputation (BNA). Care plan lacked interventions related to self medication administration. R34's Order Summary Report signed 6/11/24, included orders for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram (MG)/3 milliliter (ML) 1 vial inhale orally three times a day while awake and every four hours as needed for hypoxia. R34's Order Summary Report lacked an order to self administer medication. R34's medical record lacked documentation of a self-administration of medication (SAM) assessment completed. During a continuous observation on 6/25/24 at 8:52 a.m. - 8:57 a.m , R34 was seated in his room in his wheelchair with a mask on his face and a nebulizer running. No staff were observed in R34's room. At 8:55 a.m., trained medication aide (TMA-A) entered R34's room and shut off the nebulizer and removed the mask from R34's face. During an interview on 6/25/24 at 10:09 a.m., TMA-A verified she had placed the nebulizer treatment on R34 and exited the room. TMA-A stated she was unsure if a SAM assessment had been completed for R34. TMA-A stated her usual practice was to place the nebulizer on R34 and then return several minutes later to remove the mask for R34 when the nebulizer was completed. (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

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 06/27/2024

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/24 at 10:13 a.m. nurse manager (NM) confirmed R34 did not have a SAM assessment for the nebulizer treatment. NM stated her expectation was that since R34 had not had a SAM staff would have stayed with R34 during the nebulizer treatment to ensure R34 received the nebulizer treatment appropriately. During an interview on 6/26/24 at 12:25 p.m., director of nursing (DON) confirmed R34 had not had a SAM assessment completed. DON stated if a resident did not have a SAM assessment completed, staff were expected to remain with the resident during the entire nebulizer administration. A facility policy titled Medication Self Administration dated 2/12/24, identified residents shall have a screen completed by a licensed nurse to determine factors that may impact the safe administration of medications. Further identified residents who have been deemed appropriate to self-administer medications independently or with supervision/cuing or after set-up, shall have a physician order to do so.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview and document review, the facility failed to store tube feeding and suctioning supplies in a clean and sanitary manner for 1 of 1 residents (R7) whose supplies were left sitting out. In addition, the facility failed to maintain standing lifts shared by residents in a clean and sanitary manner. Findings include: R7's admission Minimum Data Set (MDS) dated [DATE], indicated R7 was mildly cognitively impaired and had diagnoses which included depression, chronic obstructive pulmonary disease (COPD) (COPD is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), quadriplegia (paralysis of both arms and both legs), and epilepsy (disorder that causes seizures). Identified R7 was totally dependent on staff for all transfers, activities of daily living (ADLs), and personal hygiene. During an observation on 6/24/24 at 4:31 p.m., R7 was currently hospitalized as of 6/20/24. R7 shared a room with another resident and R7's items were in the back of the room. R7's room had tube feeding and suction supplies remaining after resident was transported to the hospital on 6/20/24. Approximately 150 millimeters (mL) of cream colored tube feeding formula was left in the tube feeding bag hanging on a pole and 500 mL's of a clear fluid was left in a bag hanging on a pole next to the tube feeding. A suction machine and suction canister containing approximately 200 mL's of a clear substance with a thick white substance at the bottom was stored on R7's bed side table. The pole and bedside table were positioned to the right of R7's bed. During an observation on 6/25/24 at 9:08 a.m., R7 remained hospitalized and R7's care supplies remained the same as above. During an observation on 6/25/24 at 12:38 p.m., R7 remained hospitalized and R7's care supplies remained the same as above. During an observation and interview on 6/25/24 at 3:44 p.m., registered nurse (RN)-B confirmed the above findings. RN-B indicated nursing staff should have taken care of R7's care supplies when R7 was initially hospitalized . RN-B further indicated staff were expected to keep residents' rooms clean when residents were away from the facility. During an interview on 6/26/24 at 2:16 p.m., director of nursing (DON) confirmed the above findings and stated her expectations were if a resident was sent to the hospital all supplies would be disposed of right after the resident left. DON further stated residents' rooms were expected to be kept clean when the resident was away from the facility. Review of facility policy titled Tracheal Suctioning revision date 11/9/21, to remove secretions from the trachea or bronchi and/or stimulate the cough reflex and maintain a patent airway to promote an optimal exchange of oxygen. After suctioning discard the contaminated and disposable items in containers. (continued on next page)

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	245581	A. Building B. Wing	06/27/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Tube Feeding: Continuous Tube Feeding revision date 9/8/23, to provide nourishment to the resident who is unable to obtain nourishment orally. Discard disposable supplies in the designated containers. Clean reusable equipment according to the manufacturer's instructions. Review of facility policy titled Cleaning and Disinfection of Resident Care Equipment revision date 3/8/23, to provide guidelines for disinfection in accordance with manufacture recommendations for reusable equipment used in resident care. Reusable equipment would be cleaned and disinfected after use of one resident. Single use items would be discarded after a single use. 49014 STANDING LIFTS: During an observation on 6/24/24 at 2:46 p.m., three of the standing lifts located in the hallway on the main unit of the facility had a large area of dried yellow/brown food like substance on the lower ends of the standing lift plate of the lifts. During an observation on 6/25/24 at 8:48 a.m., the same three lifts located in the hallway on the main unit continued to have a large area of dried yellow/brown food like substance on the lower ends of the standing lift plate of the lifts. During a joint interview on 6/25/24 at 9:14 a.m., housekeeper (HK) and nursing assistant (NA)-C confirmed the presence of a dried yellow/ brown food like substance on the the lower ends of the lift plates on the three standing lifts. HK and NA-C both stated they were unsure who was responsible for cleaning the lifts. During an interview on 6/25/24 at 12:35 a.m., director of nursing (DON) stated all staff should ensure that lifts were wiped between every use including the foot plates when needed. DON stated her expectation was that all lifts would have been cleaned per policy. Review of a facility policy titled Cleaning and Disinfection of Resident Care Equipment revised 3/8/23, identified reusable equipment such as mechanical lifts would be cleaned and disinfected after use of one resident and before use of another resident.

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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 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** 49620 Based on observation, interview, and document review, the facility failed to ensure adequate supervision was provided, an accurate assessment was completed and smoking interventions were implemented to reduce the risk of avoidable injuries for 1 of 1 resident (R4) who reviewed for smoking. Findings include: R4's significant change Minimum Data Set (MDS) dated [DATE], identified R4 had moderate cognitive impairment and had diagnoses which included: dementia, psychotic disturbance, and muscle weakness. R4 was dependant on staff for supervision of bed mobility and transfers. R4's MDS also indicated R4 did not refuse cares or services. R4's significant change Care Area Assessment (CAA) worksheet dated 4/4/24, indicated R4 had complications of immobility and a history of paranoia and hallucinations. R4's care plan dated 4/12/24, identified R4 was not safe to smoke unsupervised. Care plan indicated R4 would be directly supervised (accompany the resident outside and remain with them) for the entire duration of the smoking activity and required a smoking apron. R4's current smoking assessment dated [DATE], identified the following: -Does the resident have a cognitive loss; Yes was selected -Does the resident need facility to store lighter and cigarettes; Yes was selected -Care plan is used to assure resident is safe while smoking; Yes was selected -Is the resident able to safely extinguish cigarette; Yes was selected -Is the resident able to get in and out of smoking area independently; Yes was selected -R4 was safe to smoke without supervision though required a smoking apron. -Interdisciplinary team (IDT) notes included in R4's smoking assessment identified; staff open the door for R4 to go outside due to the door having a code to get out. R4 to wear smoking apron while outside smoking, is able to light own cigarette and dispose of in proper reciprocal. A smoking apron is a flame-resistant protective covering to shield against a burning match or lit cigarette. Instructions for use per manufacturer's instructions identified the following: - Before each use, inspect apron for broken stitches or parts, torn, cut or frayed material. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Seat resident in wheelchair and drape apron over the resident. Secure the apron by engaging the hook and loop neck strap located at the top of the apron. Adjust the neck strap until the apron reaches just below the neckline. -Engaging the side straps to prevent cigarettes and ashes from falling between resident and the wheelchair, always drape the apron over the arm rests and wrap the side-straps around and under the arm rests and securely engage the side-straps hook and loop to the underside of the apron. During an observation on 6/24/24 at 12:42 p.m., R4 asked staff for a cigarette. Nursing assistant (NA)-A went to the nurse's station, brought out a smoking apron, put smoking apron on R4 and gave him a plastic container with two cigarettes and a lighter. The smoking apron was secured around R4's neck with a Velcro strap and a strap was observed to be tied together hanging on the outside of the apron halfway down the apron. NA-A opened the secure door on the memory unit, assisted R4 over the threshold, asked R4 to push the doorbell when done smoking and NA-A went back inside the facility, R4 was left outside unsupervised. There were no staff present and no video monitoring outside while R4 was smoking. R4 lit the cigarette, set the plastic bin on the ground, and proceeded to smoke. The smoking apron was observed to be folded in half on R4's chest exposing his clothing. Ashes from the cigarette were observed to be on R4's right arm, right leg of pants, right shoe, and the right side of R4's wheelchair seat in between R4 and the wheelchair armrest. R4 was observed to extinguish the cigarette on the right arm rest metal bar of the wheelchair and red and white ashes went all over on R4's clothing and the wheelchair. The cigarette receptacle was located near the exit door and one next to the green bench a few feet away from the exit door. R4 removed the smoking apron, rolled it up and set it in between him and the arm of the wheelchair. R4 propelled wheelchair with his hands on the wheels of the wheelchair over to the secured entrance door of the memory care unit. R4 kicked the bottom of the door with his right foot multiple times until staff opened the door for R4 to enter the facility. R4 waited between one and three minutes for staff to open the door. During an observation on 6/25/24 at 9:34 a.m., R4 asked staff for a cigarette. Activity aide-(A)-A went to the nurse's station, brought out a smoking apron, put smoking apron on R4 and gave him a plastic container with two cigarettes and a lighter. The smoking apron was secured around R4's neck with a Velcro strap and a strap was observed to be tied together hanging on the outside of the apron halfway down the apron. Activities staff-A opened the secure door on the memory unit and R4 went outside unsupervised. There were no staff present and no video monitoring outside while R4 was smoking. The smoking apron was observed to be folded in half over R4's chest exposing the right side of R4's clothing. R4 lit cigarette, red and white ashes dropped onto the lap of the smoking apron and rolled off onto R4's left shoe. Multiple red and white ashes dropped onto the smoking apron. R4 extinguished the cigarette in the cigarette receptacle. R4 removed the smoking apron, rolled it up and set it in between him and the arm of the wheelchair. R4 propelled wheelchair with his hands on the wheels of the wheelchair over to the secured entrance door of the memory care unit. R4 kicked the bottom of the door with his right foot multiple times until staff opened the door for him to enter the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/25/24 at 12:47 p.m., R4 was in the wheelchair with the smoke apron on, Velcro strap around R4's neck and the strap was tied together on the inside of the apron halfway down the apron. The bottom of the apron slid off R4's lap exposing the right side of R4's clothing. Licensed practical nurse (LPN)-A opened the secure door on the memory unit and R4 went outside unsupervised. R4 lit a cigarette and ash from the cigarette was observed to be on R4's clothing and shoe while smoking. R4 extinguished the cigarette on a metal chair in the courtyard. The smoking apron then became caught in the left front wheel of R4's wheelchair when R4 wheeled across the courtyard. R4 was able to wheel backwards a few feet to release the smoking apron from the left front wheel of the wheelchair. R4 lit another cigarette and ashes from the cigarette were observed on R4's jeans. R4 extinguished the cigarette on the lap of the smoking apron. R4 removed the smoking apron, rolled it up and set it in between him and the arm of the wheelchair. R4 propelled wheelchair with his hands on the wheels of the wheelchair over to the secured entrance door of the memory care unit. R4 kicked the bottom of the door with his right foot multiple times until staff opened the door for him to enter the facility. R4 waited between one and three minutes for staff to open the door. There were no staff present and no video monitoring outside while R4 was smoking. During an observation on 6/25/24 at 3:47 p.m., R4 was outside in the secure memory unit courtyard smoking unsupervised. LPN-B opened the secure door for surveyor to go outside. The smoking apron was secured around R4's neck with a Velcro strap and a strap was observed to be tied together hanging on the inside of the apron halfway down the apron. R4 extinguished the cigarette on their lap of the smoking apron. R4 requested to sit outside longer and was left unsupervised. During an interview on 6/25/24 at 12:56 p.m., NA-A confirmed R4 goes outside to smoke without supervision. NA-A stated she did not know how to monitor if R4 is safe while smoking. During an interview on 6/25/24 at 3:55 p.m., LPN-A verified smoking assessments were completed by nursing. LPN-A confirmed R4's care plan indicated direct supervision while smoking and for R4 to wear a smoking apron for safety. Follow up interview on 6/27/24 at 1:09 p.m., LPN-A verified on electronic health record (EHR) R4's care plan indicated R4 required direct supervision while smoking and to wear a smoking apron. LPN-A confirmed direct supervision means a staff member must be outside with R4 the entire time he is smoking. LPN-A stated she completed the smoking assessment on 4/24/24 for R4 by sitting outside and observing him smoke. LPN-A verified the care plan reflects the smoking assessment and was unsure why the care plan information did not match the smoking assessment. LPN-A confirmed the smoking assessment completed 4/24/24, was not accurate and did not match the care plan. During an interview on 6/25/24 at 4:27 p.m., DON verified R4's care plan indicated R4 was a smoker and was not safe to smoke and required direct supervision while smoking. Regional nurse stated the facility did a mock survey in May 2024, and at that time it was recognized that R4's smoking assessment was not correct. The DON and regional nurse did not identify why the smoking assessment had not been updated. A facility form dated 6/17/24, titled Approved Smokers List, indicated R4 needed to be supervised while smoking and required a smoking apron. Further identified designated times for supervised smoking: 9:30 a.m. , 12:30 p.m., 3:30 p.m., and 6:30 p.m. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy revised 3/9/22, titled Smoking and E-Cigarettes, indicated when a resident requested to smoke the resident would be assessed to determine the appropriate level of supervision, assistance and individualized approaches required for safety. Individualized approaches and directions for safety and assistance would be documented in the resident plan of care and communicated to direct care staff. In addition, the Smoking Policy outlined the designated areas, notices, education, and requirements for smoking on the facility property to ensure precautions are taken for the resident's individual safety as well as the safety of others in the facility.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview, and document review the facility failed to ensure administration of tube feeding formula according to physician's orders for 1 of 1 residents (R43) reviewed for tube feeding. Findings include: R43's admission Minimum Data Set (MDS) dated [DATE], indicated R43 was cognitively intact and had diagnoses which included cancer and diabetes. Identified R43 received tube feedings due to coughing/choking during meals and difficulty/pain when swallowing. Indicated R43 was independent with transfers and required set-up assistance with personal hygiene. R43's admission Care Area Assessment (CAA) dated 4/30/24, indicated R43 had a Jejunostomy (J) Tube (a soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine for supplemental feeding, hydration or medicine). and required tube feeding as a nutritional approach. Identified R43 had swallowing problems, cancer, and a recent decline in functional abilities. R43's care plan dated 6/6/24, indicated R43 had the potential for altered nutritional status related to malignant neoplasm (esophageal cancer) of the lower 1/3 of his esophagus. R43's diet type was tube feedings and regular soft diet with bite sized foods as requested by resident. Identified nursing staff were to notify the medical doctor or nurse practitioner with any significant changes. R43's Nutrition assessment dated [DATE], indicated R43 had malignant neoplasm of lower third of esophagus. Identified R43 required tube feeding to meet required caloric intake. R43's signed physician's orders dated 5/24/24, revealed an enteral feed order of Peptarmen (prescribed tube feeding formula) 1.5 per gastrostomy (G)-tube (a surgically placed device used to give direct access to your stomach for supplemental feeding, hydration or medicine) at 65 milliliters (mL) per hour via pump continuously for 24 hours. R43 signed physician's progress notes dated 5/24/24, identified R43 continued to tolerate the J tube (JPEG). R43's progress notes dated 6/24/23 through 4/22/24, revealed R43 was on continuous tube feedings of Peptamen 1.5 at 65 mL's for 20 hours and water flushes of 100 mL's every 6 hours. R43's progress notes lacked documentation R43 was refusing tube feedings or nursing staff were stopping tube feedings during the day. R43's progress notes further lacked documentation the provider, dietician, or nurse practitioner were notified of R43 refusing tube feedings or nursing staff were stopping tube feedings during the day. R43's medication administration record dated 6/1/24 through 6/30/24, feed order every four hours continuous feed, confirm with physician regarding withholding feedings. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/25/24 at 9:07 a.m., R43 was laying in his bed with the head of the bed elevated. R43 had tube feeding connected and was receiving his scheduled tube feeding. During an observation on 6/25/24 at 12:41 p.m., R43 was seated in his recliner in his room eating lunch. R43 stated he ate food during the day and received tube feedings in the evening. A blue bag that had approximately 500 mL's of liquid inside was noted on 43's bedside table. R4 indicated he vomited the liquid up prior to eating lunch. R43 further indicated he had a tumor in his esophagus and had trouble swallowing food at times. R43 stated he often vomited before he ate a meal and that it had been going on for a couple weeks. During an observation on 6/25/24 at 2:55 p.m., R43 was not in his room. R43's tube feeding bag was hanging up and had approximately 90 mL's left in the bag. Tube feeding bag was labeled and read started 2030 6/24, Pep 1.5 65 mL. Tube feeding pump was turned off. During an observation on 6/25/24 at 3:52 p.m., R43 was seated in his recliner watching television. R43 indicated staff usually shut his tube feeding pump off around 10 - 11 a.m. and they turned it back on around 7 p.m. R43 further indicated staff had been turning his tube feeding off and on around the same times for the past couple weeks. R43 revealed he used to be on the tube feeding pump full time however the past couple weeks he had been eating more so staff had been shutting it off during the day. Called the dietician on 6/26/24 at 12:06 p.m., however no answer and never received a call back. During an interview on 6/26/24 at 1:30 p.m., registered nurse (RN)-C confirmed R43's orders for continuous tube feedings. RN-C indicated R43 had refused the tube feeding during the day. RN-C stated she entered R43's room and unhooked his tube feeding and gave him his medications. RN-C confirmed she did not document R43's refusal for tube feeding during the day. During an interview on 6/26/24 at 1:34 p.m., licensed practical nurse (LPN)-C confirmed R43's orders for 20 hours continuous tube feedings. LPN-C indicated R43 had been refusing his tube feedings so nursing staff would stop his tube feedings around 9 a.m. and start them again around 8 p.m. During an interview on 6/26/24 at 2:07 p.m., director of nursing (DON) confirmed the above findings and indicated she was in contact with the dietician on Monday 6/24/24, to discuss updated orders for R43. DON further indicated the dietician changed R43's tube feeding orders from continuous 24 hours to continuous 20 hours. DON stated she was not aware nursing staff were shutting R43's tube feeding pump off during the day. DON indicated she thought nursing staff were following the physician and dietician's orders. DON stated her expectations were nursing staff should be documenting when a resident was refusing care and notify the provider or dietician to update them. DON identified it was important that orders were being followed and residents needs were being met Facility policy titled Tube Feeding: Continuous Tube Feeding revised date 9/8/23, to provide nourishment to the resident who was unable to obtain nourishment orally. Verify physician order for formula, rate, and flush.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview and document review, the facility failed to provide oxygen therapy as ordered by the physician for 1 of 1 resident (R14) who utilized oxygen to maintain adequate oxygen saturation levels. Findings include: R14's significant change Minimum Data Set (MDS) dated [DATE], indicated R14 was cognitively intact and had diagnoses which included depression, chronic obstructive pulmonary disease (COPD) (COPD is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and respiratory failure. R14's care area assessment (CAA) dated 5/25/24, indicated R14 had respiratory disease and required maximum assistance with activities of daily living (ADLs). The CAA lacked documentation R14 was to receive continuous oxygen therapy. R14's signed physicians orders dated 5/24/24, indicated R4 was to receive continuous oxygen therapy via nasal cannula (NC) at 2 liters (L) during all shifts to keep saturation levels above 90%. R14's care plan, revised 3/25/24, indicated R14 had asthma related to COPD and was on continuous oxygen therapy. R14 was to receive oxygen therapy as ordered. Review of Shortness of Breath Eval dated 6/26/24, indicated R14 had shortness of breath or trouble breathing with exertion, when sitting at rest, and when laying flat. During a continuous observation on 6/25/24: - At 9:26 a.m., R14 was in the dining room in her wheelchair. R14 was not receiving continuous oxygen therapy while sitting in the dining room. R14 had a portable oxygen tank on the back of her wheelchair but no oxygen tubing was observed connected to the tank. - At 9:32 p.m., R14 continued to sit in the dining room without continuous oxygen therapy. R14 stated she was feeling short of breath (SOB). -At 9:50 a.m., R14 continued to sit in the same position as noted above without continuous oxygen therapy. -At 9:57 a.m., R14 asked activity staff to get her oxygen tubing from her room because she was feeling (SOB). Activity staff walked to R14's room, obtained her oxygen tubing and was walking back to the dining room. Prior to oxygen tubing being placed on R14, asked registered nurse (RN)-A to obtain R14's oxygen saturations. RN-A indicated she was unable to apply oxygen to R14 at this time because she was discharging another resident from the facility. RN-A further indicated R14 would need to wait until she was finished with the discharge. RN-A continued to make copies at that time. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During an observation and interview at 10:01 am, RN-A grabbed O2 saturation machine from the medication cart and walked to dining room where R14 was playing bingo. R14 was sitting in her wheelchair and told RN-A she felt SOB. R14 further requested to have oxygen connected. RN-A obtained R14's saturations prior to administering oxygen. R14's saturations were 79%. RN-A connected oxygen tubing to oxygen concentrator in dining room, set oxygen to 2L, and placed nasal cannula in R14's nose. R14 continued to indicate she was still feeling SOB even after having oxygen placed. R14 took several deep breaths after oxygen was placed to increase oxygen saturation levels. RN-A confirmed the above findings and verified R14 did not have oxygen on while in the dining room. RN-A confirmed R14's continuous oxygen orders and indicated R14 was to have continuous oxygen at 2L on at all times to keep saturations above 90%. During an interview on 6/26/24 at 1:49 p.m., director of nursing (DON) confirmed the above finding and verified R14 was to have continuous oxygen at 2 L on at all times to keep saturations above 90%. DON stated her expectations were residents were to received oxygen per providers orders and nursing staff were to ensure orders were being followed. Facility policy titled Physician Orders revision date 7/6/21, to provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards. Facility policy titled Oxygen Administration and Storage revision date 6/15/23, to ensure staff follow safety guidelines and regulation for storage and use of oxygen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49014 Based on observation, interview, and document review, the facility failed to ensure food and beverages stored in the refrigerators and freezers were labeled, dated and discarded properly. In addition, the facility failed to ensure dishes were sanitized when dishwashing temps were not reaching the required temperatures. Further, the facility failed to ensure staff were wearing proper hair restraints such as hair and beard nets and ensure safe delivery of beverages during dining observation. This deficient practice had the potential to affect all 45 residents who received food and beverages from the refrigerators and freezers. Findings include: On 6/24/24 at 11:23 a.m., during the initial tour of the kitchen area with the dietary manager (DM) the following concerns were identified: Walk in produce cooler: - 1/3 container of opened buttermilk with an expiration date of 6/6/24. -1/3 large container of poppyseed dressing with an opened date of 12/23/23. -1/2 large container of ranch dressing without notation of an open date. - jar of opened pickles belonging to staff without a notation of a date opened. Fridge in kitchen: -3/4 container of sour cream without notation of an open date. - opened container of hazelnut creamer without notation of an open date. Freezer: -package of seven waffles without notation of an open date. -one of the three compartment sink areas had a thick black/gray wet substance on and around the edges of the sink. During an observation on 6/24/24 at 11:40 a.m., dietary aide (DA)-A was standing at the dishwasher washing dishes. Dishwasher wash temp was 113 degrees Fahrenheit (F) The engraved sign on the chemical dishwasher indicated the machine wash was to reach 120 degrees F. When dishes were finished washing DA-A pulled rack out of the dishwasher and left dishes in the rack. DA-A had not sprayed any sanitizer on the dishes after removing them from the dishwasher. DA-A stated he was unaware of what to do when the dishwasher wash temp did not reach 120 degrees (F). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility dishwasher temperature logs identified dishwasher temps were between 106 degrees F and 130 degrees F. for the past month. During an observation on 6/24/24 at 5:15 p.m., dietary aide (DA)-A was standing at the steam table in the main dining room dishing up residents food and wearing a baseball cap backwards which did not cover his hair which was touching his shoulders. DA-A had a beard that was one inch long and was not wearing a beard net over his facial hair. DA-A stated he was allowed to wear a baseball cap instead of a hair net as long as his hair was not longer than shoulder length. DA-A further stated he did not need to wear a beard net since his facial hair was not very long. 49620 During an observation on 6/24/24 at 4:46 p.m., a steam table was brought down the hallway and placed by the nurses desk of the memory care unit by dietary aide (DA)-A. For the entire observation of preparing of food by DA-A, and beverages by DA-B for the memory care residents, DA-A and DA-B were not wearing hairnets. Dietary aide (DA)-A was standing at the steam table in the hallway of the memory care unit dishing up resident's food and wearing a baseball cap backwards which did not cover his hair which was touching his shoulders. DA-A had a beard that was one inch long and was not wearing a beard net over his facial hair. DA-A stated he was allowed to wear a baseball cap instead of a hair net as long as his hair was not longer than shoulder length. Three carts were observed in the hallway near the steam table, setup with a tray for each resident labeled with the resident name, food preferences and any special instructions, silverware and drink glasses. There were a total of 11 trays. DA-B removed two clear plastic drink glasses from a tray, entered the kitchenette area, filled the glasses with juice, milk or water and carried the glasses holding the top rim with his bare hands back to the tray on the cart. DA-B repeated this step for a total of 11 times touching the top rim of the clear plastic glasses every time he returned the filled glasses from the kitchenette to the tray on the cart. During an interview on 6/24/24 at 4:54 p.m., DA-B confirmed he touched the top rim of the glasses with his bare hands. DA-B stated this practice could spread bacteria to the residents and cause illness. During an interview on 6/26/24 at 9:24 a.m., dietary manager (DM) verified staff were trained on how to hold glasses to prevent contamination. DM stated the expectation that staff perform proper hygiene and hold glasses towards the bottom portion of the glass not touching the top rim with bare hands to prevent a resident from getting ill and infection control. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 6/25/24 at 9:52 a.m., DM verified the above findings and stated her expectations were that food should have been dated as soon as it was opened. DM verified they were unable to locate the manufacturer's instructions for the dishwasher however indicated a call was placed to the manufacturer which verified the dishwasher was a chemical dishwasher. DM stated the dishwasher temps had not been reaching maximum temperature for the past month and when dish wash temps did not reach the correct temperature, staff were expected to use a food safe sanitizer to spray the dishes for one minute and allow the dishes to air dry until the representative was able to come and fix the dishwasher. DM stated she had thought it was appropriate for staff to wear a baseball cap even with longer hair and that beards only needed to be covered when they reached a certain length. The DM further stated the three compartment sink was used on occasion to rinse dishes and she would have expected staff to ensure the kitchen and equipment were clean and to follow the facility cleaning policy. Review of facility policy, Food Safety Requirements undated, indicated the facility would provide safe and sanitary storage, handling and consumption of all foods. The policy indicated proper labeling and dating of each item and cover containers, secure wrapping and left overs would be used within three days or discarded. Review of a facility policy titled Personal Cleanliness and Hygienic Practices revised 6/3/13, identified all dietary staff, including the Dietary Manager, and any person entering the kitchen, must wear an approved hair restraint to keep hair and particles in the hair from falling into the food. Identified hair restraints must entirely cover all hair. Further identified food handlers with facial hair should also wear beard restraints. In addition, indicated all plates, utensils and drinking cups would be handled in a way to avoid touching eating surfaces.

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 48583 Based on interview and document review, the facility failed to ensure the State agency (SA) was notified as required when the current director of nursing (DON) was appointed to their position. This deficient practice had the potential to affect all 45 residents in the facility. Findings include: During the extended survey on 6/27/24, evidence was requested to demonstrate the SA had been notified when the DON was hired to her position. During an interview on 6/27/24 at 1:22 p.m., administrator and DON confirmed the SA was not notified when DON was hired to her position. Administrator further indicated he believed it was no longer a requirement. Review of facility document titled DON Job Description prepared date 4/17/12, job description acknowledgement was signed by the DON on 10/9/23. No further information was provided.

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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. 49014 Based on observation, interview and document review, the facility failed to ensure personal laundry was transported in a manner that prevented risk of contamination for 1 of 5 hallways observed for linen transportation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. During an observation on 6/25/24 at 9:08 a.m., nursing assistant (NA)-B was walking down the hall carrying soiled bed linen with her bare hands against her clothing, dropped a soiled pillowcase on the floor and bent down with her bare hands and picked the pillowcase off the floor and proceeded to place the soiled linen in a cart in the soiled utility room and performed hand hygiene. During an interview on 6/25/24 at 9:11 a.m., NA-B confirmed she had carried soiled bed linen which contained urine with her bare hands against her clothing from R34's room. NA-B stated she should have worn gloves and placed the soiled linen in a bag before bringing into the hallway. During an observation on 6/26/24 at 7:42 a.m., nurse manager (NM) had been in and out of several residents room and then proceeded to the clean utility room and retrieved a clean hoyer sling. NM then proceeded to walk down the hall carrying the clean hoyer sling across her left shoulder, touching her clothing. NM entered R9's room and assisted NA-E in placing the hoyer sling under R9. NA-E and NM proceeded to transfer R9 into her wheelchair using the hoyer sling and the hoyer lift. During an interview on 6/26/24 at 7:48 a.m., NM confirmed she had taken a clean hoyer sling and placed it over her shoulder, touching her clothing as she walked down the hall after providing care to other residents. NM stated she should not have placed the clean hoyer sling against her clothing to prevent the spread of infections. During an interview on 6/26/26 at 12:50 a.m., director of nursing (DON) and infection preventionist (IP) stated her expectation was that staff would have worn gloves and placed soiled linen in a bag before transporting it through the hallway and that staff would carry all clean linen away from the body to prevent the spread of infections. Review of a facility policy titled Handling Linens and Laundry revised 1/16/23, identified staff should Consider all soiled linen to be potentially infectious and never carry soiled linen against the body. Further identified clean linen should be kept in a clean linen cart.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 48583 Based on interview and document review, the facility failed to provide mandatory training on the facility specific QAPI (Quality Assurance and Performance Improvement) program to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. Findings include: Review of facility's New Employee Orientation Guide, Relias Training Essentials part 1 through 4, and Nursing and Rehab Employee Handbook dated 1/22, lacked documentation on QAPI training for employees. During an interview on 6/27/2024 at 1:02 p.m., nursing assistant (NA)-D indicated she did not know what QAPI was. During an interview on 6/27/2024 at 1:09 p.m., licensed practical nurse (LPN)-A confirmed she did not know what QAPI was or what it stood for. LPN-A indicated the facility used to have a big board and a group of people would get together to review falls however the facility had got away from doing that anymore. LPN-A stated only immediate staff and upcoming staff would get together to discuss concerns on the memory care unit. During an interview on 6/27/24 at 1:11 p.m., LPN-E confirmed she was not aware of what QAPI was. During an interview on 6/27/24 01:25 p.m., trained medical aid (TMA)-B indicated she had no idea what QAPI was and was never told about QAPI. During an interview on 6/27/24 at 1:57 p.m., director of nursing (DON) indicated she was not aware staff were not being trained on QAPI. DON stated it was important for staff to know about QAPI because it informed them of the current quality projects being addressed and explained what needed to be improved. DON further stated she wanted staff to know what was going on in the facility. Requested a QAPI training policy, however one was not provided.