DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 02S1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00360

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245280**

2. STATE VENDOR OR MEDICAID NO. (L2) **285042700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEVIEW METHODIST HEALTH CARE CENTER**
(L4) **610 SUMMIT DRIVE**
(L5) **FAIRMONT, MN** (L6) **56031**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **1/5/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 01/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 3/3/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **06/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245280

January 24, 2017

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

Dear Ms. Barnes:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 23, 2016 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

January 24, 2017

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: Project Number S5280026

Dear Ms. Barnes:

On December 20, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 14, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 5, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 5, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 14, 2016, effective December 23, 2016 and therefore remedies outlined in our letter to you dated December 20, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245280	A. Building B. Wing	1/5/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.21(b)(3)(ii) LSC	Correction Completed 12/23/2016	ID Prefix F0312 Reg. # 483.24(a)(2) LSC	Correction Completed 12/23/2016	ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 12/23/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 1/24/2017	SIGNATURE OF SURVEYOR 03048	DATE 1/5/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245280	A. Building 02 - THE CHAPEL B. Wing	1/5/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0346	Correction Completed 12/16/2016	ID Prefix Reg. # NFPA 101 LSC K0354	Correction Completed 12/16/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 1/24/2017	SIGNATURE OF SURVEYOR 35482	DATE 1/5/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 02S1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00360

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245280**

2. STATE VENDOR OR MEDICAID NO. (L2) **285042700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEVIEW METHODIST HEALTH CARE CENTER**
(L4) **610 SUMMIT DRIVE**
(L5) **FAIRMONT, MN** (L6) **56031**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification** **3. Termination** **4. CHOW** **5. Validation** **6. Complaint** **7. On-Site Visit** **9. Other** **8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/14/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Kalis, HFE NE II 12/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/23/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above : _____

22. ORIGINAL DATE OF PARTICIPATION **06/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 20, 2016

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: Project Number S5280026

Dear Ms. Barnes:

On December 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 23, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 23, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 14, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility follow the plan of care related to oral care for 1 of 1 resident (R48) reviewed for dental. Findings include: The significant change Minimum Data Set (MDS) assessment dated 10/26/16, indicated R38 had moderate cognitive impairment, required extensive staff assistance with bed mobility,	F 282	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law. Resident R 48□s care plan states to have oral care after meals. Staff education, to	12/23/16

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

Electronically Signed | 12/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene; in addition, R48 had likely cavity or broken natural teeth. R48's care plan dated 10/31/16, identified an ADL (activities of daily living) self-care performance deficit related to limited ROM (range of motion) and limited mobility. Interventions included: ORAL CARE ROUTINE AM, PC (after meals), HS (bedtime): brush teeth, rinse dentures, rinse mouth. Resident has history of severe stomatitis (An inflammation of the mucous lining of the mouth, which may involve the cheeks, gums, tongue, lips, and roof or floor of the mouth.) and needs good oral cares after each meal. When interviewed on 12/14/16, at 11:53 a.m. nursing assistant (NA)-A confirmed she assisted R48 with oral cares that morning. NA-A stated R48 brushed his own teeth after staff provide set-up assistance and would then assist with the rest as needed. NA-A stated she assists R48 with oral cares before breakfast unless he asks to wait until after the meal. NA-A stated R48 had never requested teeth brushing after lunch and confirmed she does not ask R48 whether he would like to brush his teeth after lunch. NA-A further stated the resident usually eats candy after lunch and is more interested in having that. When interviewed on 12/14/16, at 12:47 p.m. NA-B confirmed she worked with R48 regularly and staff set-up R48's toothbrushing supplies and R48 independently brushes the few teeth he has left but that staff brush his upper denture. NA-B stated staff assist R48 with oral care twice a day -morning and night. Following the noon lunch meal on 12/14/16, at	F 282	care managers and nursing staff, regarding following care plans was completed by Resident Care Coordinator on 12/14/16. Nurse aide sheets were reprinted to include oral care standards as written on care plan. Effective on 12/14/16 a task was completed in Point Click Care electronic medical records to notify and track at all meal times that oral care was offered and completed. Director of Nursing and Resident Care Coordinator will audit the electronic chart to assure care plan is being followed. Resident interviewed on 12/21/16 to assure resident is in agreeance of the care plan. He stated that he would like to be the one to brush his own teeth and to have the staff help him set it up after meals. Care plan was updated for set up and provide assistance and encouragement to brush teeth after meals. To enhance currently compliant operations and under the director of nurses and Resident Care Coordinator all staff will receive education on following resident care plans. Audits will be done to assure compliance, and the findings of the audits will be addressed quarterly at the quality assurance committee meeting for further review by the Director of Nursing and Resident Care Coordinator. Auditing will be continued until it goes through the QA&A committed for review and acceptance. All staff will be educated on following care plans on 12/23/2016 by the director of nursing.	

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F 282	Continued From page 2 12:58 p.m. NA-B propelled R48 from the dining room to his room. NA-C was then observed to enter R48's room with the EZ stand lift to assist with toileting. After exiting the room, NA-C was interviewed and stated R48 was assisted with oral care twice a day unless he requested more often. NA-C confirmed she would not offer assistance with oral care/brushing teeth other than during AM and HS cares unless R48 requested. NA-C further confirmed R48 was not offered nor had he requested oral care be provided after lunch today [12/14/16]. When interviewed on 12/14/16, at 1:14 p.m. registered nurse (RN)-B confirmed expectations would be to offer R48 assistance with oral cares after every meal per the plan of care. When interviewed on 12/14/16, at 1:37 p.m. the director of nursing (DON) stated he would expect staff to approach R48 after meals and ask to perform oral cares per the plan of care.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oral care was completed for 1 of 1 resident (R48) reviewed for dental. Findings include:	F 312	Resident R 48□s care plan states to have oral care after meals. Staff education, to care managers and nursing staff, regarding following care plans was completed by Resident Care Coordinator on 12/14/16. Nurse aide sheets were reprinted to include oral care standards as	12/23/16

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F 312	Continued From page 3 The significant change Minimum Data Set (MDS) assessment dated 10/26/16, indicated R38 had moderate cognitive impairment, required extensive staff assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene; in addition, R48 likely had cavity or broken natural teeth. R48's care plan dated 10/31/16, identified an ADL (activities of daily living) self-care performance deficit related to limited ROM (range of motion) and limited mobility. Interventions included: ORAL CARE ROUTINE AM, PC (after meals), HS (bedtime): brush teeth, rinse dentures, rinse mouth. Resident has history of severe stomatitis (An inflammation of the mucous lining of the mouth, which may involve the cheeks, gums, tongue, lips, and roof or floor of the mouth.) and needs good oral cares after each meal. When interviewed on 12/14/16, at 11:53 a.m. nursing assistant (NA)-A confirmed she assisted R48 with oral cares that morning. NA-A stated R48 brushed his own teeth after staff provide set-up assistance and would then assist with the rest as needed. NA-A stated she assists R48 with oral cares before breakfast unless he asks to wait until after the meal. NA-A stated R48 had never requested teeth brushing after lunch and confirmed she does not ask R48 whether he would like to brush his teeth after lunch. NA-A further stated the resident usually eats candy after lunch and is more interested in having that. When interviewed on 12/14/16, at 12:47 p.m. NA-B confirmed she worked with R48 regularly and staff set-up R48's toothbrushing supplies and R48 independently brushes the few teeth he has left but that staff brush his upper denture. NA-B	F 312	written on care plan. Effective on 12/14/16 a task was completed in Point Click Care electronic medical records to notify and track at all meal times that oral care was offered and completed. Director of Nursing and Resident Care Coordinator will audit the electronic chart to assure care plan is being followed. Resident interviewed on 12/21/16 to assure resident is in agreeance of the care plan. He stated that he would like to be the one to brush his own teeth and to have the staff help him set it up after meals. Care plan was updated for set up and provide assistance and encouragement to brush teeth after meals. To enhance currently compliant operations and under the director of nurses and Resident Care Coordinator all staff will receive education on following resident care plans. Audits will be done to assure compliance, and the findings of the audits will be addressed quarterly at the quality assurance committee meeting for further review by the Director of Nursing and Resident Care Coordinator. Auditing will be continued until it goes through the QA&A committed for review and acceptance. All staff will be educated on following care plans on 12/23/2016 by the director of nursing.	

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F 312	Continued From page 4 stated staff assist R48 with oral care twice a day -morning and night. Following the noon lunch meal on 12/14/16, at 12:58 p.m. NA-B propelled R48 from the dining room to his room. NA-C was then observed to enter R48's room with the EZ stand lift to assist with toileting. After exiting the room, NA-C was interviewed and stated R48 was assisted with oral care twice a day unless he requested more often. NA-C confirmed she would not offer assistance with oral care/brushing teeth other than during AM and HS cares unless R48 requested. NA-C further confirmed R48 was not offered nor had he requested oral care be provided after lunch today [12/14/16]. When interviewed on 12/14/16, at 1:14 p.m. registered nurse (RN)-B confirmed expectations would be to offer R48 assistance with oral cares after every meal per the plan of care. When interviewed on 12/14/16, at 1:37 p.m. the director of nursing (DON) stated he would expect staff to approach R48 after meals and ask to perform oral cares. DON stated it used to be a task for the NA's and was just reinstated today as it had fallen off point of care. The DON further stated the expectation would be that staff offer R48 assistance with oral cares after meals as he was not sure that R48 would approach staff and request oral cares completed.	F 312		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention	F 441		12/23/16

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F 441	Continued From page 5 and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 441		

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F 441	Continued From page 6 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure staff, visitors and residents were alerted of special contact precautions for 1 of 1 resident (R87) reviewed and diagnosed with clostridium difficile (C-diff). This has the potential to affect staff, visitors and residents who fail to implement proper contact precautions. Findings include: During the initial tour on 3rd floor on 12/12/16, at 1:40 p.m. it was noted there was no signage to indicate to staff and visitors that R87 required any special contact precautions. R87, who resides on the 3rd floor, had diagnosis of enterocolitis due to	F 441	In regards to residents on infectious isolation we have updated our isolation policy to include laundry droplet precautions, laundry for contact precautions, laundry for airborne precautions, and staff and visitor education as of 12/14/16. All staff were provided education regarding infection of a resident that is placed into isolation for; including but not limited to proper handwashing protocol, handling of laundry for the resident and PPE to be worn. Isolation cart will have a sign on top indicating what room it is for, signs will be hung on the resident□s door directing visitors to see the nurse for education,	

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F 441	Continued From page 7 C-diff and had a positive stool culture results noted on 11/6/16. During interview and observation on 12/12/16, at 2:05 p.m. licensed practical nurse (LPN)-A verified there was no signage on R87's room door indicating there was any special contact precautions required and/or directions for staff, visitors and residents to see the nurse prior to entrance . LPN-A further verified there was no special handwashing alert in the room to indicate soap and water handwashing were required to prevent the spread of C-diff vs. only the use of hand sanitizers which were not effective in eliminating the spores. LPN-A indicated there was an infection control manual available at each nursing station as a reference tool. During an interview on 12/13/16, at 3:00 p.m. the infection control registered nurse (RN)-A verified that R87 was to be on contact precautions for C-diff infection and there was no signage on the entrance to R87's room to indicate visitors should check with nursing staff. RN-A indicated staff were aware of the precautions and there was a newly updated infection control manual located at each nursing station for reference. RN-A further confirmed there were no instructions related to the proper hand hygiene/handwashing posted for staff and/or visitors entering the room. Following an observation of morning cares for R87 on 12/14/16, at 7:26 a.m. nursing assistant (NA)-D indicated, "We wash our hands with soap and water or hand sanitizer". NA-D further verified she was unaware that proper handwashing included the use of soap/water following cares with R87 (C-diff infection) to prevent cross contamination. Upon completion of the interview,	F 441	signs will be hung in the room to remind staff and visitors to wash their hands. Policy for Personal Protective Equipment has been updated as of 12/14/16. Included is visitor□s education for PPE. Stating if a resident in isolation has visitors, a sign will be posted on the resident□s door directing visitors to see the nurse prior to entering the room. The nurse should educate the resident on proper hand washing and any PPE that should be worn and how to dispose of it when they leave. On 12/14/16 our C-diff policy was updated to include Set up infection control bedside table that has a sign with an assigned room number taped to the top, hang a sign on the door directing visitors to see the nurse prior to entering for education and handwashing, and signs in the room for proper washing for staff and visitors (with soap and water, not alcohol rubs) and hamper for resident. Also included is update on laundry that is soiled with stool needs to be bagged in yellow bags and sent to laundry. If it is a large amount of stool this needs to be taken to the soiled utility room and rinsed prior to being sent to laundry. Ensure proper PPE is worn and the hopper is properly disinfected after use. Effective 12/14/16, each isolation cart will have a booklet regarding isolation cart instructions, Signs for doors, handwashing, and for cart with room number, quick facts in regards to c-diff for staff education, quick facts about MRSA and VRE for staff education, proper donning and doffing of PPE and finally a list of staff roles and tasks and the correct	

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F 441	Continued From page 8 NA-D removed the soiled gloves and washed with soap and water prior to leaving R87's room. When interviewed on 12/14/16, at 11:12 a.m. housekeeper (HK)-A verbalized the procedure utilized to clean a room for a resident who required special precautions due to C-diff. , explaining the special cleaner utilized. However, HK-A then indicated there were no residents on 3rd floor that required any special isolation precautions/cleaning. Review of the annual training material (attended by all nursing staff), 2016 Relias Learning, in the section titled C. Diff it specified "Because alcohol-based hand rubs are not effective in killing this organism, it is imperative that you wash your hands thoroughly with soap and water after caring for an individual with C. diff to reduce the risk of cross-contamination". The policy and procedure titled, Isolation Precautions, undated, indicates appendix A from CDC should be followed (attached to the policy). It further indicated that handwashing with soap and water was preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs.	F 441	PPE to be worn. To enhance currently compliant operations and under the direction of the Director of nurses and the infection control officer all staff will receive in-service training regarding state and federal requirements for infection control. Training will emphasize the importance of proper infection control techniques and education. Audits will be done to assure compliance, and the findings of the audits will be addressed quarterly at the quality assurance committee meeting for further review by the Director of Nursing and infection control officer. Auditing will be continued until it goes through the QA&A committed for review and acceptance. All staff will be educated on following care plans on 12/23/16 by the director of nursing.	

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	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/14/2016**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPTS OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 14, 2016. At the time of this survey, Building 01 of Lakeview Methodist Health Care Center was NOT found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Lakeview Methodist Health Care Center was constructed as follows: Building 01 consists of the 1963, 1978 and 1993 buildings. Building 01 is three stories in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; Building 02 represents the 2000 addition, and consists of a chapel, main entrance, business offices, mechanical room and a link to an assisted living facility. This addition is one-story	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2016

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.

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K 000	Continued From page 1 in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. 2-hour fire wall assemblies separate both the buildings of Type II(111) construction from the addition of Type V(111) construction, and, the nursing home from an assisted living facility. Opening protectives consist of labeled, self-closing, positive latching, 90-minute fire door assemblies. In accordance with NFPA 101 (2012) Chapter 19, Table 19.1.6.2, a three-story building of Type V(111) construction is not permitted. As such, the facility was surveyed as two-buildings, and two Form CMS-2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 56 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 346 SS=E	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview,	K 346	Contact information was updated to	12/16/16

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LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

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K 346	Continued From page 2 the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. The deficient practice could affect 56 out of 56 residents. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/14/2016, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current staff contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346	current staff information. Director of building services responsible for monitoring and compliance. Date completed 12/16/16	
K 354 SS=E	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler	K 354		12/16/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 354	Continued From page 3 system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. The deficient practice could affect 56 out of 56 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/14/2016, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current staff contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354	Current staff and out of service time information was updated on 12/16/16. Director of Building services responsible for monitoring and compliance. Date completed 12/16/16.	
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier	K 372		12/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 4 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1. (1). This deficient practice could affect 56 of 56 residents by allowing smoke to propagate from one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM	K 372	All penetrations at smoke barriers D/B and D/E were filled with approved fire sealant. Director of building services responsible for monitoring and compliance. Date completed 12/19/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/14/2016**

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LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

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K 372	Continued From page 5 on 12/14/2016, observation during the inspection revealed penetrations above the lay-in ceiling at the 3rd floor smoke barriers D/B and D/E. These deficient practices were verified by the Facility Maintenance Director.	K 372		
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 56 of the 56	K 920	One extra power strip was brought to room 220 and Christmas light plugs were devided between the two power strips. Director of building services responsible for monitoring and compliance. Date	12/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

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K 920	Continued From page 6 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/14/2016, observation revealed a power strip in Resident Room (220) being overloaded with Christmas light plugs. This deficient practice was verified by the Facility Maintenance Director.	K 920	completed 12/14/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**12/14/2016**

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LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on 12/14/16. At the time of this survey, Building 02 of Lakeview Methodist Health Care Center was NOT found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Lakeview Methodist Health Care Center was constructed as follows: Building 01 consists of the 1963, 1978 and 1993 buildings. Building 01 is three stories in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; Building 02 represents the 2000 addition, and consists of a chapel, main entrance, business offices, mechanical room and a link to an assisted living facility. This addition is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. 2-hour fire wall assemblies separate both the buildings of Type II(111) construction from the addition of Type V(111) construction, and, the nursing home from an assisted living facility. Opening protectives consist of labeled, self-closing, positive latching, 90-minute fire door assemblies.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**12/14/2016**

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LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

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K 000	Continued From page 1 In accordance with NFPA 101 (2012) Chapter 19, Table 19.1.6.2, a three-story building of Type V(111) construction is not permitted. As such, the facility was surveyed as two-buildings, and two Form CMS-2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of beds and had a census of 56 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 346 SS=E	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. The deficient practice could affect 56 out of 56 residents. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the	K 346	Contact information was updated to current staff information on 12/16/16. Director of building services responsible for monitoring and compliance. Date completed 12/16/16	12/16/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**12/14/2016**

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LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

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K 346	Continued From page 2 fire alarm system has been returned to service. 9.6.1.6 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/14/2016, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current staff contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346		
K 354 SS=E	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. The deficient practice could affect 56 out of 56 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been	K 354	Current staff and out of service times information was updated on 12/16/16. Director of building services responsible for monitoring and compliance. Date completed 12/16/16	12/16/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**12/14/2016**

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K 354	Continued From page 3 determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 12/14/2016, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current staff contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
December 20, 2016

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5280026

Dear Ms. Barnes:

The above facility was surveyed on December 12, 2016 through December 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	12/14/2016

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LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	12/14/2016

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/12/16 to 12/14/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility follow the plan of care related to oral care for 1 of 1 resident (R48) reviewed for dental. Findings include: The significant change Minimum Data Set (MDS) assessment dated 10/26/16, indicated R38 had moderate cognitive impairment, required extensive staff assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene; in addition, R48 had likely cavity or broken natural teeth. R48's care plan dated 10/31/16, identified an ADL (activities of daily living) self-care performance deficit related to limited ROM (range of motion) and limited mobility. Interventions included: ORAL CARE ROUTINE AM, PC (after meals), HS (bedtime): brush teeth, rinse dentures, rinse mouth. Resident has history of severe stomatitis	2 565	Completed on 12/23/16	12/23/16

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	00360	A. BUILDING: _____ B. WING _____	12/14/2016

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LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

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2 565	Continued From page 3 (An inflammation of the mucous lining of the mouth, which may involve the cheeks, gums, tongue, lips, and roof or floor of the mouth.) and needs good oral cares after each meal. When interviewed on 12/14/16, at 11:53 a.m. nursing assistant (NA)-A confirmed she assisted R48 with oral cares that morning. NA-A stated R48 brushed his own teeth after staff provide set-up assistance and would then assist with the rest as needed. NA-A stated she assists R48 with oral cares before breakfast unless he asks to wait until after the meal. NA-A stated R48 had never requested teeth brushing after lunch and confirmed she does not ask R48 whether he would like to brush his teeth after lunch. NA-A further stated the resident usually eats candy after lunch and is more interested in having that. When interviewed on 12/14/16, at 12:47 p.m. NA-B confirmed she worked with R48 regularly and staff set-up R48's toothbrushing supplies and R48 independently brushes the few teeth he has left but that staff brush his upper denture. NA-B stated staff assist R48 with oral care twice a day -morning and night. Following the noon lunch meal on 12/14/16, at 12:58 p.m. NA-B propelled R48 from the dining room to his room. NA-C was then observed to enter R48's room with the EZ stand lift to assist with toileting. After exiting the room, NA-C was interviewed and stated R48 was assisted with oral care twice a day unless he requested more often. NA-C confirmed she would not offer assistance with oral care/brushing teeth other than during AM and HS cares unless R48 requested. NA-C further confirmed R48 was not offered nor had he requested oral care be provided after lunch today [12/14/16].	2 565		

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2 565	Continued From page 4 When interviewed on 12/14/16, at 1:14 p.m. registered nurse (RN)-B confirmed expectations would be to offer R48 assistance with oral cares after every meal per the plan of care. When interviewed on 12/14/16, at 1:37 p.m. the director of nursing (DON) stated he would expect staff to approach R48 after meals and ask to perform oral cares per the plan of care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about the importance of following the plan of care. The DON or designee, could randomly audit to be sure the plans of care is being followed to provide proper nursing care for the residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oral care was completed for 1 of 1 resident (R48) reviewed for dental.	2 920	Completed on 12/23/16	12/23/16

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2 920	Continued From page 5 Findings include: The significant change Minimum Data Set (MDS) assessment dated 10/26/16, indicated R38 had moderate cognitive impairment, required extensive staff assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene; in addition, R48 likely had cavity or broken natural teeth. R48's care plan dated 10/31/16, identified an ADL (activities of daily living) self-care performance deficit related to limited ROM (range of motion) and limited mobility. Interventions included: ORAL CARE ROUTINE AM, PC (after meals), HS (bedtime): brush teeth, rinse dentures, rinse mouth. Resident has history of severe stomatitis (An inflammation of the mucous lining of the mouth, which may involve the cheeks, gums, tongue, lips, and roof or floor of the mouth.) and needs good oral cares after each meal. When interviewed on 12/14/16, at 11:53 a.m. nursing assistant (NA)-A confirmed she assisted R48 with oral cares that morning. NA-A stated R48 brushed his own teeth after staff provide set-up assistance and would then assist with the rest as needed. NA-A stated she assists R48 with oral cares before breakfast unless he asks to wait until after the meal. NA-A stated R48 had never requested teeth brushing after lunch and confirmed she does not ask R48 whether he would like to brush his teeth after lunch. NA-A further stated the resident usually eats candy after lunch and is more interested in having that. When interviewed on 12/14/16, at 12:47 p.m. NA-B confirmed she worked with R48 regularly and staff set-up R48's toothbrushing supplies and	2 920		

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2 920	Continued From page 6 R48 independently brushes the few teeth he has left but that staff brush his upper denture. NA-B stated staff assist R48 with oral care twice a day -morning and night. Following the noon lunch meal on 12/14/16, at 12:58 p.m. NA-B propelled R48 from the dining room to his room. NA-C was then observed to enter R48's room with the EZ stand lift to assist with toileting. After exiting the room, NA-C was interviewed and stated R48 was assisted with oral care twice a day unless he requested more often. NA-C confirmed she would not offer assistance with oral care/brushing teeth other than during AM and HS cares unless R48 requested. NA-C further confirmed R48 was not offered nor had he requested oral care be provided after lunch today [12/14/16]. When interviewed on 12/14/16, at 1:14 p.m. registered nurse (RN)-B confirmed expectations would be to offer R48 assistance with oral cares after every meal per the plan of care. When interviewed on 12/14/16, at 1:37 p.m. the director of nursing (DON) stated he would expect staff to approach R48 after meals and ask to perform oral cares. DON stated it used to be a task for the NA's and was just reinstated today as it had fallen off point of care. The DON further stated the expectation would be that staff offer R48 assistance with oral cares after meals as he was not sure that R48 would approach staff and request oral cares completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure residents requiring assistance with oral care receive the necessary services. The DON or designee could educate all	2 920		

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2 920	Continued From page 7 appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		12/23/16

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21390	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure staff, visitors and residents were alerted of special contact precautions for 1 of 1 resident (R87) reviewed and diagnosed with clostridium difficile (C-diff). Findings include: During the initial tour on 3rd floor on 12/12/16, at 1:40 p.m. it was noted there was no signage to indicate to staff and visitors that R87 required any special contact precautions. R87, who resides on the 3rd floor, had diagnosis of enterocolitis due to C-diff and had a positive stool culture results noted on 11/6/16. During interview and observation on 12/12/16, at 2:05 p.m. licensed practical nurse (LPN)-A verified there was no signage on R87's room door indicating there was any special contact precautions required and/or directions for staff, visitors and residents to see the nurse prior to entrance . LPN-A further verified there was no special handwashing alert in the room to indicate soap and water handwashing were required to prevent the spread of C-diff vs. only the use of hand sanitizers which were not effective in eliminating the spores. LPN-A indicated there was an infection control manual available at each nursing station as a reference tool. During an interview on 12/13/16, at 3:00 p.m. the infection control registered nurse (RN)-A verified that R87 was to be on contact precautions for C-diff infection and there was no signage on the entrance to R87's room to indicate visitors should check with nursing staff. RN-A indicated staff	21390	Completed on 12/23/16	

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21390	Continued From page 9	21390		

were aware of the precautions and there was a newly updated infection control manual located at each nursing station for reference. RN-A further confirmed there were no instructions related to the proper hand hygiene/handwashing posted for staff and/or visitors entering the room.

Following an observation of morning cares for R87 on 12/14/16, at 7:26 a.m. nursing assistant (NA)-D indicated, "We wash our hands with soap and water or hand sanitizer". NA-D further verified she was unaware that proper handwashing included the use of soap/water following cares with R87 (C-diff infection). Upon completion of the interview, NA-D removed the soiled gloves and washed with soap and water prior to leaving R87's room.

When interviewed on 12/14/16, at 11:12 a.m. housekeeper (HK)-A verbalized the procedure utilized to clean a room for a resident who required special precautions due to C-diff. , explaining the special cleaner utilized. However, HK-A then indicated there were no residents on 3rd floor that required any special isolation precautions/cleaning.

Review of the annual training material (attended by all nursing staff), 2016 Relias Learning, in the section titled C. Diff it specified "Because alcohol-based hand rubs are not effective in killing this organism, it is imperative that you wash your hands thoroughly with soap and water after caring for an individual with C. diff to reduce the risk of cross-contamination".

The policy and procedure titled, Isolation Precautions, undated, indicates appendix A from CDC should be followed (attached to the policy). It further indicated that handwashing with soap

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21390	Continued From page 10 and water was preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures are maintained. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		