Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 17, 2023

Administrator
Lakewood Health System
401 Prairie Avenue Northeast
Staples, MN 56479

RE: CCN: 245420
Cycle Start Date: November 8, 2023

Dear Administrator:

On November 8, 2023, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 February 8, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by May 8, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

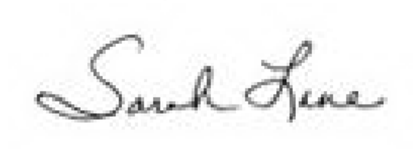
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245420	A. BUILDING _____ B. WING _____	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD HEALTH SYSTEM	401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479

(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
E 000	Initial Comments On 11/6/23 to 11/8/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/6/23 to 11/8/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed: The following complaints were reviewed with no deficiency issued. H54206792C (MN00097883), H54206798C (MN00091303), H54206842C (MN00090960), H54206801C (MN00090155), H54206799C (MN00087881), H54206794C (MN00087736), H54206800C (MN00084947). The following complaint was reviewed H54206791C (MN00087392) with a deficiency	F 000		

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

Electronically Signed | 11/20/2023

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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F 000	Continued From page 1 issued at F607. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages	F 576		11/20/23

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F 576	Continued From page 2 and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident mail was delivered on Saturdays for 5 of 5 residents (R2, R40, R46,R49, R27) who voiced concerns with mail delivery. This deficient practice had the potential to affect all 74 residents residing in the facility. Findings include: During a resident council meeting on 11/7/23 at 2:02 p.m., five residents attended. All five residents, R2, R40, R46, R49, R27, confirmed mail was not delivered on Saturdays at the facility, and they had to wait until Monday to receive their mail. During an interview on 11/7/23 at 3:09 p.m., activity assistant (AA)-A indicated activity staff	F 576	Resident Mail: All residents will receive their USPS mail and deliveries on Saturdays as evidenced by a secured mail receptacle that was installed on 11/20/2023. This mail will be gathered each Saturday by activities staff or designee. This mail will be sorted and distributed by activities or designee on each Saturday to residents. This process will be audited by the Activity Coordinator or designee via signature sign off with date of pick up and delivery to residents each Saturday. This will be effective Saturday, November 25, 2023. This will be audited weekly for 90 days and reported to QAPI each month. Will follow QAPI recommendations. Goal is 100% compliance.	

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F 576	Continued From page 3 delivered mail to residents. AA-A stated they did not deliver mail to residents on Saturday and indicated mail had not been delivered to the facility on Saturdays. During an interview on 11/7/23 at 3:15 p.m., business office assistant (BOA)-A indicated she sorted the mail the residents received on Monday through Fridays and placed the mail activity mail box for resident delivery. BOA-A indicated she was unsure if mail was delivered on Saturdays. During an interview on 11/8/23 at 11:50 a.m., administrator confirmed mail was not delivered to residents on Saturdays and indicated it did not get delivered to the facility on Saturdays. The facility policy titled Resident Mail, dated 4/17/22, identified residents had the right to send and promptly receive mail. The policy identified facility staff would deliver resident's personal mail to their room, unopened.	F 576	New protocol was emailed to Customer Experience and Activities on 11/21/23 to include mail delivery to be completed by Activities Staff for each Saturday starting 11/25/23. Activity Coordinator trained all staff on new protocol by 11/24/23 with the exception of 1 who was out on COVID leave and was trained on date of return 11/30/23. Saturday mail delivery will be monitored by Activity Coordinator by audit review. Activity staff will sign off on mail pick up and delivery each Saturday. Activity Coordinator will audit with residents to ensure they received Saturday mail the following week.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		11/20/23

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F 585	Continued From page 4 facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for	F 585		

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F 585	Continued From page 5 example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585		

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F 585	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grievance procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired, for 5 of 5 residents (R2, R40, R46, R49, R27) reviewed for grievances. This deficient practice had the potential to affect all 74 residents residing in the facility. Findings include: During a resident council meeting on 11/7/23 at 2:02 p.m., five residents attended. All five residents, R2, R40, R46, R49, R27, confirmed they were not aware of how to file a grievance at the facility. During an interview on 11/7/23 at 4:00 p.m., social service assistant (SSA)-A indicated the grievance procedure was reviewed upon admission with the residents and a copy of the procedure was included in the admission packet. SSA-A stated three facility staff members were listed on the grievance procedure form for residents or representatives to contact if they had a concern, or they could contact the ombudsman. SSA-A indicated if residents wished to file a grievance, they could talk to social services or the charge nurse who could provide them information on who they could contact. During an interview on 11/7/23 at 4:07 p.m., director of nursing (DON) stated residents in the facility could report grievances to any staff member or charge nurse. DON indicated she understood residents who attended resident	F 585	Grievances: Grievance posters were updated to demonstrate a larger font and poster size. They are now hung in different prominent locations on the Care Center Unit, where other important postings are posted as well. These posters are hung at variable height options for viewing by residents, staff, visitors, etc. The grievance verbiage was changed to highlight options for anonymous reporting. Residents and their primary contact were educated on the grievance process via letter. Grievance Officer will present at the upcoming Resident Council December 20, 2023. Grievance process will be reviewed monthly at Resident Council indefinitely, as it is a standing agenda item now. DON or appointed designee will audit Resident Council minutes to ensure the Grievance process is reviewed and residents were able to tell us how they can file a Grievance, including anonymously. Each resident will be offered a copy of the minutes, after the President and VP of Resident Council give permission for release, each month by the Activity Staff. Will review with QAPI monthly x90 days, and accept recommendations from the committee. Goal is for 100% compliance. All staff educated on updated signage, locations, and policy. Policy was reviewed and no updates needed.	

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F 585	Continued From page 7 council meetings were informed they could contact social services if they had concerns and they would assist them with the grievance process either by addressing their concerns internally or assisting with filing a grievance. DON and surveyor observed the eight by eleven inch framed grievance procedure located on the wall across from the chapel office, approximately five feet off the ground. DON indicated the facility had recently reviewed the grievance process and posting and had discussed whether the height of the posting and location were adequate. DON confirmed the grievance procedure was not posted in any other prominent locations in the facility. DON verified the facility had not identified how residents could file a grievance anonymously. DON stated the facility did not have any forms for residents to file anonymous grievances. During an interview on 11/8/23 at 11:50 a.m., administrator indicated the facility used a formal grievance process that was used for all campuses. Administrator confirmed the only location of the grievance procedure was in the facility's main corridor across from the chapel/activity room. Administrator confirmed the facility's procedure for grievances, including how to file anonymously, was to contact one of the three staff members listed on the procedure. The facility posting titled Grievance Procedure, undated, identified if concern or suggestions, the facility encouraged them to notify the nurse in charge. If the matter could not be resolved by the charge nurse, they could contact the director of nursing, director of programs and operations, or the grievance officer, whose names, phone numbers and e-mails were listed. The procedure	F 585		

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F 585	Continued From page 8 identified grievances may be filed orally or in written format, and may be done so anonymously. The facility policy titled Lakewood Health System (LHS) System Grievance Policy revised 3/20/23, identified its purpose was to provide all customers of LHS a procedure to follow for reporting concerns and grievances with services, care, or other elements of their experience within LHS, and whom to contact to file a grievance. The policy indicated concerns excluded from being defined as grievances included; billing concerns, patient satisfaction survey comments unless a written and signed complaint was included with the survey requesting resolution, and post-care verbal communication that would routinely have been handled by staff present if the communication had occurred during the stay, and anonymous concerns. The policy identified all customers were encouraged to notify any front line staff or charge nurse of their concern. If the concern was unable to be resolved promptly, the concern would be documented within the department as a point-of-care concern. Concerns that were unable to be resolved would be forwarded to director of nursing, director of social services, vice president of senior services, or customer experience, and would be logged as a grievance. The policy identified grievances may be received in person, phone, voicemail, e-mail or in writing, or attached to patient satisfaction survey as a signed document requesting resolution.	F 585		
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		11/20/23

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F 607	Continued From page 9 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the posting of conspicuous signage of employee rights related to retaliation against the employee for reporting a suspected crime. This deficiency has the potential to affect all 74 residents currently residing in the facility. Findings include: During an observation on 11/8/23, a tour of the	F 607	Retaliation Poster: Retaliation Poster was placed on Staff Education Board 11/08/2023. Staff electronic education was reviewed for non-retaliation clause for reporting abuse and neglect on 11/08/2023. Posted non-retaliation clause will be audited for continued posting on staff education board weekly for three months with 100% compliance of posted staff information.	

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	245420	A. BUILDING _____ B. WING _____	C 11/08/2023

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F 607	Continued From page 10 facility revealed the facility lacked signage of employee rights related to retaliation prohibition for reporting suspicions of a suspected crime posted within the facility. During an interview on 11/8/23 at 1:25 p.m., licensed practical nurse (LPN)-A reported that no retaliation was not addressed in the abuse policy online and staff reviewed it annually. Could not identify where employee rights related to retaliation were posted. During an interview on 11/8/23 at 1:30 p.m., director of program and operations verified employee rights related to retaliation prohibition for reporting suspicions of a suspected crime were not posted. . During an interview on 11/8/23 at 2:00 p.m., administrator verified employee rights related to retaliation were not posted. Review of the facility policy titled Vulnerable Adult Policy dated 9/28/23, identified the facility was prohibited from retaliating against a person who reported suspected maltreatment in good faith.	F 607	These audits will be completed by Director of Programs/Operations and administrative assistant. This will be audited for 100% compliance for 90 days and reported to QAPI each month.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		11/20/23

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F 623	Continued From page 11	F 623		

Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;

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F 623	Continued From page 12 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure	F 623		

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F 623	Continued From page 13 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the ombudsman of a facility initiated transfer for 1 of 1 residents (R9) reviewed for hospitalization. Findings include: R9's quarterly Minimum Data Set (MDS) dated 9/11/23, identified R9 was cognitively intact, and had diagnoses which included: stroke, hemiplegia (one sided paralysis or weakness) and peripheral vascular disease (blood circulation disorder). Indicated R9 required assistance with self care and mobility. Review of R9's progress notes from 8/28/23 to 8/30/23, identified the following: - on 8/28/23 at 1:17 p.m., nurse was notified from nurse at vascular appointment, that the procedure went well, but R9's blood pressure dropped significantly. R9 was being admitted for observation, with plan to return to facility the next day. Family notified and verbal bed hold completed. - on 8/30/23 at 12:20 p.m., R9 returned to the facility. During an interview on 11/7/23 at 10:49 a.m., social service designee (SSD)-A indicated her	F 623	Transfer and Discharge Notice: The Transfer and Discharge Notice, along with Bed Hold form, will be audited for completion and notification to Ombudsman, for each resident transfer to a certified bed outside of Lakewood Health System Care Center. Each occurrence will be audited by DON or appointed designee for 90 days and reported to QAPI monthly. Will follow QAPI recommendations. Goal is 100% compliance. The resident effected was allowed to return to the facility after hospital DC, to his room, that the bed was held for during his hospitalization. The bed hold was completed initially with the resident and family when we were notified of the resident going from a Clinic visit, to the Hospital for an overnight stay d/t a change in condition during the clinic appointment. The documentation for the bed hold being obtained, was in the EMR from the nurse who took the call, and had the conversation with the family and resident of his transfer to the hospital. Family and resident requested to hold the bed, and this was documented by the nurse at the time of the transfer, in the EMR. Charting reflected that resident and family were	

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F 623	Continued From page 14 usual process was to send the transfer notification to the Ombudsman* When did she do this and how?* and place the form into the resident's medical record. During a follow-up interview on 11/7/23 at 1:02 p.m., SSD-A confirmed the Ombudsman had not been notified of R9's hospital transfer. SSD-A indicated it was important to notify the Ombudsman of hospital transfers, so if concerns existed regarding returning to the facility, the Ombudsman would be aware of the transfer. During an interview on 11/8/23 at 2:00 p.m., director of programs and operations (DPO)-A confirmed she oversaw the social service department. DPO-A indicated the usual facility process for hospital transfers included the nurses would complete a transfer form, which was then provided to social service, which would trigger them to notify the Ombudsman. DPO-A stated it was her expectation social services notified the Ombudsman by fax of all transfers. DPO-A indicated it was important for resident advocacy and to protect the residents right to come back to the facility. DPO-A confirmed the above findings. A policy was requested however was not provided.	F 623	counseled on right to return to Care Center on day of the transfer from Clinic appt to the Hospital for admission. Transfer/DC Notice and Bed Hold forms completed and faxed to Ombudsman. Education was given to all staff to inform of this process and clear expectation of the conversation to be held with the family/resident, as well as the paperwork that is needed to be completed in this process. Policy was reviewed, no updates were needed.	

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K 000	INITIAL COMMENTS An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/07/2023. At the time of this survey, Lakewood Health System Nursing Home was found not in 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC 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. UPON RECEIPT 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/20/2023

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 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lakewood Health Systems Care Center is a 1-story building with a partial basement. The building was constructed in 1976, was determined to be of Type II (000) construction. A dining room addition was constructed in 1992 to the south east, is one story, without a basement and was determined to be Type II (000) construction. The 1965 old hospital building, which is separated from the 1976 building with a 2- hour fire barrier, has a partial basement, is a Type II (000) construction, has been remodeled and part of it is part of the Lakewood Health System Care Center.	K 000		

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K 000	Continued From page 2 The building is fully sprinkler protected and has a manual fire alarm system with smoke detection in the sleeping rooms, corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 87 beds and had a census of 74 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, 7.1.10.1, and 7.2.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/07/2023 at 12:30 PM, it was revealed by observation that the marked emergency exit door in the corridor by the memory care was lined up with 6 3x5 foot laundry carts that were being	K 211	Means of Egress: Will ensure laundry carts are not located in hallways and stored elsewhere when needed to keep hallways free of all obstructions in the case of emergency. Maintenance will audit this weekly for 90 days. Goal is to achieve 100% compliance. Will review at QAPI monthly.	11/20/23

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K 211	Continued From page 3 stored with linen for an extended length of time. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 211		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility	K 324	Stove in Memory Care: Maintenance Supervisor did order the	11/20/23

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K 324	Continued From page 4 failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/07/2023 at 12:40 AM, it was revealed by observation that the lock-out switch installed on the residential stove located in Memory Care was not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 324	recommended part that is needed for this stove to meet in accordance with the guidance per the Fire Marshall. This will be replaced and put into place by 11/27/23.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 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	K 920		11/20/23

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K 920	Continued From page 5 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/07/2023 between 10:00 AM and 2:30 PM, it was revealed by observation in room 213 there was an air mattress plugged into a power strip. 2. On 11/07/2023 between 10:00 AM and 2:30 PM, it was revealed by observation in room 113 there was an extention cord plugged into a multi-plug adapter. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 920	Power Cords and Extension Cords: Care Center Staff educated on regulation that power cords and extension cords are not allowed for us in our facility. Maintenance team performed an initial audit while MDH onsite to remove all of these. They will audit this weekly for 90 days. Goal is to achieve 100% compliance. Will review at QAPI monthly.	