DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 23, 2022

CMS Certification Number (CCN): 245420

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

Dear Administrator:

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 July 26, 2022 the above facility is certified for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 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/or 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

DEPARTMENT OF HEALTH

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Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles. This letter addresses the Health survey only.

Electronically Delivered
August 23, 2022

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

RE: CCN: 245420
Cycle Start Date: June 29, 2022

Dear Administrator:

On August 1, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have 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
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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 06/29/2022

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 6/26/22, to 6/29/22, 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 6/26/22, to 6/29/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H54202869C (MN84503), with a deficiency cited at F609. AND The following complaints were found to be UNSUBSTANTIATED: H54202664C(MN84448). H54202889C (MN84367). H5420070C (MN82767). H5420069C (MN82479). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/26/2022

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 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 substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		7/26/22

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F 609	Continued From page 2 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse were immediately reported to the State Agency (SA), no later than 2 hours after knowledge of the allegation of abuse, for 1 of 1 residents (R60) reviewed for allegations of abuse. Findings include: R60's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 6/10/22, identified R60 had diagnoses which included quadriplegia, arthritis and depression. The MDS identified R60 had intact cognition, and required extensive assistance with activities of daily living of bed mobility, transfers, toileting and was dependent for all locomotion. R60's undated nursing assistant care plan, revealed R60 had situational stressors and identified interventions of reapproaching R60 at a later time, provide reassurance, anticipate her needs and record any behaviors. The facility SA report reviewed identified the allegation of abuse occurred on 6/22/22, at 5:42 am. The SA report was submitted by the facility on 6/22/22, at 9:04 a.m., three hours and 22 minutes after the incident occurred. R60's medical record lacked documentation of her allegation of staff abuse. During a telephone interview on 6/28/22, at 1:18 p.m. nursing assistant (NA)-A stated on 6/22/22, at approximately 5:45 a.m. NA-B had requested	F 609	Becky, Director of Programs and Operations, will provide education on VA reporting to all departments that work directly in the Care Center setting. Education will include the time of reporting requirement. Facility will follow plan of care for resident to provide reassurance, anticipate her needs, and record any behaviors. Plan of care has been updated since incident to reflect increase in staff available for this resident for cares, 2 assist, as well as increased monitoring to ensure we are meeting her needs in a satisfactory manor. Facility will audit the VA reporting process to ensure that is is followed per policy and regulation, so that we are protecting all residents in our care. Care audits will be completed 2x/week for 3 months and be brought to monthly QAPI for review to evaluate. Immediate care concerns with audits or other findings will be handled immediately. If policy is not followed by staff, it will result in disciplinary action and up to termination. Education to all facility staff will be assigned through computer-based learning modules format. All staff will have this completed by 7/31/22. Becky and her team will audit all future VA reports for timely reporting for 3 months and then re-evaluate. This will be brought to the monthly QAPI meeting to review audits and provide guidance and recommendations, based on results of the audits.	

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F 609	Continued From page 3 assistance with providing cares to R60. NA-A indicated when she entered R60's room, R60 was lying on her back in bed, an inch from the end of the bed. NA-A stated R60 was screaming, crying about how poorly she had been treated by NA-B shortly before NA-A entered the room. NA-A stated she had never seen R60 so upset and indicated R60 had told her she felt she had been treated like a dog. NA-A indicated at that time; NA-B began to verbally disagree with R60 about her reports of poor treatment. NA-A stated she told NA-B to leave the room and provided cares to R60 by herself. NA-A indicated R60 was calm when she left the room at approximately 6:15 a.m. NA-A stated she did not report R60's concerns to the night charge nurse. However, NA-A indicated she reported R60's complaints of poor treatment by NA-B to registered nurse (RN)-A when she started her shift at approximately 6:55 a.m. During an interview on 6/28/22, at 12:58 p.m. the director of nursing (DON) stated she had been notified on 6/22/22, R60 had reported rough treatment by an NA. The DON stated she was aware the SA report was submitted past the two-hour reporting requirement. The DON stated, upon learning of the incident, RN-A went to R60's room and spent time with her to ensure she felt safe prior to submitting a vulnerable adult report to the SA. During an interview on 6/28/22, at 1:34 p.m. RN-A stated on 6/22/22, at approximately 6:30 a.m. she was notified of R60's report of staff-abuse by NA-A. RN-A stated she immediately went to R60's room to gather information and to ensure R60 felt safe and comfortable. RN-A indicated it had taken awhile to get R60 to calm down and	F 609		

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F 609	Continued From page 4 she had been in her room with her for approximately 30-45 minutes. RN-A stated after she met with R60, she notified the social worker, the DON, and the facility administrator and then submitted a report to the SA at approximately 9:00 a.m. During an interview on 6/29/22, at 10:02 a.m. the facility administrator stated the facility policy and protocol for reports of abuse would be to report to the SA immediately, no later than two hours. The administrator stated she had been made aware of R60's report on 6/22/22, and was aware the SA report was submitted later than the two-hour timeframe. She indicated she felt it was more important to ensure R60 felt safe, and her emotional needs were met prior to submitting the SA report. Review of facility policy titled, Vulnerable Adult Policy effective 6/20/22, revealed the facility would provide a system of protected services to adults, who may show reasonable, cause of incidence of abuse, neglect, misappropriation of property or injuries of unknown source. The policy identified the facilty had the responsibility of safeguarding the rights and welfare of the physically, mentally, and emotionally vulnerable adults. The policy indicated all alleged violations would have been reported immediately but not later than two hours, if alleged violation involves abuse, or results in serious bodily injury, serious bodily injury -immediately but not later than two hours after forming the suspicion.	F 609		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		7/26/22

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F 812	Continued From page 5 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food items were properly stored and dated in 1 of 1 kitchens and 2 of 2 kitchenettes in the facility to prevent food borne illness. This deficient practice had the potential to affect 73 of 74 residents who were served food from the main kitchen and kitchenettes. Findings include: During the initial kitchen tour with the baker-cook (BC) on 6/26/22, at 1:40 p.m. the following observations were made: The walk-in refrigerator storing milk and dairy products was noted to have: A crate containing approximately five half pint	F 812	Bobbijo, Dietary Manager, will complete education on labeling, dating, and storage of foods for all department staff by 8/15/22. She will audit this twice weekly for 3 months and then re-evaluate. This will be brought to the monthly QAPI meeting to review audits and provide guidance and recommendations, based on results of the audits. Facility audit process will ensure that we are not putting other residents at risk for foodborne illness r/t outdated/unlabeled food items. Facility has not had any foodborne illness related to this.	

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F 812	Continued From page 6 non-fat milk cartons with a use-by-date of 6/18/22, and approximately 15 cartons with a use-by-date of 6/20/22. A crate containing approximately eight pint-sized heavy whipping cream bottles with a use-by-date of 6/25/22. During an interview on 6/26/22, at 1:50 p.m. the BC stated she was not certain why the outdated items listed above were still in the refrigerator. BC immediately disposed of the outdated items from the walk-in refrigerator. During the second kitchen tour with the dietary manager (DM) on 6/28/22, at 10:00 a.m. the following observations were made: The freezer compartment of the refrigerator located in the kitchenette on the memory unit was noted to have three bags of food products without labels or dates and inside the bags the food items were covered in a heavy layer of ice. The food items included a bag containing three waffles, a bag of French toast sticks, and a bag with a single egg omelet. The DM stated the items should have had labels. DM commented the items were freezer burnt and immediately disposed of them. The multi-door refrigerator located in the main dining room kitchenette was noted to have food products that were beyond the use-by-date. Those products included: One single size yogurt container had a use-by-date of 6/20/22. The DM immediately threw the container away in the trash receptacle.	F 812		

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F 812	Continued From page 7 One half pint size non-fat milk carton had a use-by-date of 6/16/22, and five more half pint sized non-fat milk cartons with use-by-dates noted to be 6/22/22. The DM immediately threw the cartons away in the trash receptacle. During an interview on 6/28/22, at 10:00 a.m. the DM stated she had been informed outdated food products were also found during the initial kitchen tour completed on 6/26/22. During a follow-up interview on 6/29/22, at 11:35 a.m. DM stated her expectation for her staff would be to check the use by dates of the food upon food deliveries. Additionally, DM indicated she expected staff to properly seal and date food products once they had been opened. Review of the facility kitchen's policy titled Food Storage revised 3/17/19, revealed foods with expiration dates were to be used prior to the date on the package. The policy indicated all foods would be covered, labeled, and dated. The policy identified refrigerated foods would be checked to assure that foods (including leftovers) would be consumed by their safe use by dates, or frozen (where applicable) or discarded. The policy indicated frozen foods would be covered, labeled, dated and all foods would be checked to assure that foods would be consumed by their safe use by dates or discarded.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 814		7/26/22

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F 814	Continued From page 8 Based on observation and interview, the facility failed to ensure proper containment of garbage in the outside dumpsters to prevent harboring pests and rodents. This had the potential to affect all 74 residents residing in the facility. Findings include: On 6/28/22, at 10:20 a.m. during the kitchen sanitation tour, the facility's two outside dumpsters were observed located at the end of the back parking lot next to an area of vegetation and wildlife. The dumpster on the left had one lid open, exposing the interior of the dumpster. The Dietary Manager (DM) stated at the time the dumpsters were used for recycling. DM stated housekeeping staff disposed of dietary's refuse, such as cardboard boxes from food deliveries, into the dumpsters. On 6/29/22, at 9:50 a.m. the two dumpsters were observed and both dumpster lids were open. During an interview on 6/29/22, at 10:00 a.m. the Maintenance Supervisor (MS) confirmed the dumpster lids were open and stated housekeeping or any staff using the dumpsters should have ensured the lids were closed. During a telephone interview on 6/29/22, at 1:00 p.m. Housekeeping Director (HKD) stated the facility did not have a policy for proper containment of refuse in the dumpsters. HKD stated housekeeping staff disposed of the refuse once daily and were expected to ensure the lids were closed after the task was completed. HKD indicated the dumpsters were located next to an area where active wildlife had been observed.	F 814	Jerry, Maintenance Manager, called the garbage company on 6/29/22 and notified them that the dumpster needed to be moved and kept on a solid surface at all times. They have given education to their team to continue this forward. Maintenance and Housekeeping Managers will provide education to all department staff by 8/15/22. Maintenance will audit this weekly as well as Housekeeping will audit this weekly, to make a twice weekly audit for at least 3 months then re-evaluate. This will be brought to the monthly QAPI meeting to review audits and provide guidance and recommendations, based on results of the audits.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 23, 2022

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

Re: Reinspection Results
Event ID: 157Y12

Dear Administrator:

On August 1, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 29, 2022. At this time these correction orders were found corrected.

Please feel free to call me with 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

Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles. This letter addresses the Health survey only.

Electronically delivered
July 19, 2022

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

RE: CCN: 245420
Cycle Start Date: June 29, 2022

Dear Administrator:

On June 29, 2022, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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 September 29, 2022 (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 December 29, 2022 (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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 19, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 157Y11

Dear Administrator:

The above facility was surveyed on June 26, 2022 through June 29, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 immediately contact:

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

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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245420	A. BUILDING **NN - LAKEWOOD NURSING HOME** B. WING _____	**07/19/2022**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/19/2022. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/09/2022

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
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 2 and part of it is part of the Lakewood Health System Care Center. 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 76 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K 914		8/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 914	Continued From page 3 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect electrical outlets on an annual basis per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4.1.1, and 6.3.4.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/19/2022, between 12:00 PM to 2:00 PM, a review of the available documentation revealed that records could not be provided to show that an annual electrical outlet inspection had occurred since 2020. An interview with the Maintenance Director verified this finding at the time of discovery.	K 914	Electrical inspection completed by Electrician on 8/5/22, without concerns. We had a changeover in Electricians, where one went on leave and then wasn't able to return. The new Electrician has now taken over and has set up a reminder system to avoid this from occurring in the future. This didn't effect any resident care. It was an isolated incident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00667	A. BUILDING: _____ B. WING _____	C 06/29/2022

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

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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: On 6/26/22, to 6/29/22, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was found to be	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 SUBSTANTIATED: H54202869C (MN84503), with a licensing order issued at 1985. The following complaints were found to be UNSUBSTANTIATED: H54202664C(MN84448). H54202889C(MN84367). H5420070C (MN82767). H5420069C (MN82479). 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
21735	MN Rule 4658.1420 Solid Waste Disposal Solid wastes, including garbage, rubbish, recyclables, and other refuse must be collected, stored, and disposed of in a manner that will not create a nuisance or fire hazard, nor provide a breeding place for insects or rodents. Accumulation of combustible material or waste in unassigned areas is prohibited. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper containment of garbage in the outside dumpsters to prevent harboring pests and rodents. This had the potential to affect all 74 residents residing in the facility. Findings include: On 6/28/22, at 10:20 a.m. during the kitchen sanitation tour, the facility's two outside dumpsters were observed located at the end of the back parking lot next to an area of vegetation	21735	Jerry, Maintenance Manager, called the garbage company on 6/29/22 and notified them that the dumpster needed to be moved and kept on a solid surface at all times. They have given education to their team to continue this forward. Maintenance and Housekeeping Managers will provide education to all department staff by 8/15/22. Maintenance will audit this weekly as well as Housekeeping will audit this weekly, to make a twice weekly audit for at least 3	7/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21735	Continued From page 3 and wildlife. The dumpster on the left had one lid open, exposing the interior of the dumpster. The Dietary Manager (DM) stated at the time the dumpsters were used for recycling. DM stated housekeeping staff disposed of dietary's refuse, such as cardboard boxes from food deliveries, into the dumpsters. On 6/29/22, at 9:50 a.m. the two dumpsters were observed and both dumpster lids were open. During an interview on 6/29/22, at 10:00 a.m. the Maintenance Supervisor (MS) confirmed the dumpster lids were open and stated housekeeping or any staff using the dumpsters should have ensured the lids were closed. During a telephone interview on 6/29/22, at 1:00 p.m. Housekeeping Director (HKD) stated the facility did not have a policy for proper containment of refuse in the dumpsters. HKD stated housekeeping staff disposed of the refuse once daily and were expected to ensure the lids were closed after the task was completed. HKD indicated the dumpsters were located next to an area where active wildlife had been observed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review, revise procedures related to the use and maintenance of the outside garbage receptacles. The administrator or designee could provide staff education and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21735	months then re-evaluate. This will be brought to the monthly QAPI meeting to review audits and provide guidance and recommendations, based on results of the audits.	

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21985	Continued From page 4	21985		
21985	MN St. Statute 626.557 Subd. 3a Reporting - Maltreatment of Vulnerable Adults Subd. 3a. Report not required. The following events are not required to be reported under this section: (a) A circumstance where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected maltreatment, unless the vulnerable adult, or the vulnerable adult's guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent to the disclosure of suspected maltreatment from each patient or resident, or a guardian, conservator, or legal representative, upon the patient's or resident's admission to the facility. Persons who are prohibited by federal law from reporting an incident of suspected maltreatment shall immediately seek consent to make a report. (b) Verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies. (c) Accidents as defined in section 626.5572, subdivision 3. (d) Events occurring in a facility that result from	21985		7/26/22

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21985	Continued From page 5 an individual's error in the provision of therapeutic conduct to a vulnerable adult, as provided in section 626.5572, subdivision 17, paragraph (c), clause (4). (e) Nothing in this section shall be construed to require a report of financial exploitation, as defined in section 626.5572, subdivision 9, solely on the basis of the transfer of money or property by gift or as compensation for services rendered. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse were immediately reported to the State Agency (SA), no later than 2 hours after knowledge of the allegation of abuse, for 1 of 1 residents (R60) reviewed for allegations of abuse. Findings include: R60's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 6/10/22, identified R60 had diagnoses which included quadriplegia, arthritis and depression. The MDS identified R60 had intact cognition, and required extensive assistance with activities of daily living of bed mobility, transfers, toileting and was dependent for all locomotion. R60's undated nursing assistant care plan, revealed R60 had situational stressors and identified interventions of reapproaching R60 at a later time, provide reassurance, anticipate her needs and record any behaviors. The facility SA report reviewed identified the allegation of abuse occurred on 6/22/22, at 5:42	21985	Becky, Director of Programs and Operations, will complete education on VA reporting to all departments that work directly in the Care Center setting. This will be assigned through computer-based learning modules format. All staff will have this completed by 7/31/22. Becky and her team will audit all future VA reports for timely reporting for 3 months and then re-evaluate. This will be brought to the monthly QAPI meeting to review audits and provide guidance and recommendations, based on results of the audits.	

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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) COMPLETE DATE
21985	Continued From page 6 am. The SA report was submitted by the facility on 6/22/22, at 9:04 a.m., three hours and 22 minutes after the incident occurred. R60's medical record lacked documentation of her allegation of staff abuse. During a telephone interview on 6/28/22, at 1:18 p.m. nursing assistant (NA)-A stated on 6/22/22, at approximately 5:45 a.m. NA-B had requested assistance with providing cares to R60. NA-A indicated when she entered R60's room, R60 was lying on her back in bed, an inch from the end of the bed. NA-A stated R60 was screaming, crying about how poorly she had been treated by NA-B shortly before NA-A entered the room. NA-A stated she had never seen R60 so upset and indicated R60 had told her she felt she had been treated like a dog. NA-A indicated at that time; NA-B began to verbally disagree with R60 about her reports of poor treatment. NA-A stated she told NA-B to leave the room and provided cares to R60 by herself. NA-A indicated R60 was calm when she left the room at approximately 6:15 a.m. NA-A stated she did not report R60's concerns to the night charge nurse. However, NA-A indicated she reported R60's complaints of poor treatment by NA-B to registered nurse (RN)-A when she started her shift at approximately 6:55 a.m. During an interview on 6/28/22, at 12:58 p.m. the director of nursing (DON) stated she had been notified on 6/22/22, R60 had reported rough treatment by an NA. The DON stated she was aware the SA report was submitted past the two-hour reporting requirement. The DON stated, upon learning of the incident, RN-A went to R60's room and spent time with her to ensure she felt safe prior to submitting a vulnerable adult report to the SA.	21985		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00667	A. BUILDING: _____ B. WING _____	C 06/29/2022

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

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21985	Continued From page 7 During an interview on 6/28/22, at 1:34 p.m. RN-A stated on 6/22/22, at approximately 6:30 a.m. she was notified of R60's report of staff-abuse by NA-A. RN-A stated she immediately went to R60's room to gather information and to ensure R60 felt safe and comfortable. RN-A indicated it had taken awhile to get R60 to calm down and she had been in her room with her for approximately 30-45 minutes. RN-A stated after she met with R60, she notified the social worker, the DON, and the facility administrator and then submitted a report to the SA at approximately 9:00 a.m. During an interview on 6/29/22, at 10:02 a.m. the facility administrator stated the facility policy and protocol for reports of abuse would be to report to the SA immediately, no later than two hours. The administrator stated she had been made aware of R60's report on 6/22/22, and was aware the SA report was submitted later than the two-hour timeframe. She indicated she felt it was more important to ensure R60 felt safe, and her emotional needs were met prior to submitting the SA report. Review of facility policy titled, Vulnerable Adult Policy effective 6/20/22, revealed the facility would provide a system of protected services to adults, who may show reasonable, cause of incidence of abuse, neglect, misappropriation of property or injuries of unknown source. The policy identified the facilty had the responsibility of safeguarding the rights and welfare of the physically, mentally, and emotionally vulnerable adults. The policy indicated all alleged violations would have been reported immediately but not later than two hours, if alleged violation involves abuse, or results in serious bodily injury, serious	21985		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21985	Continued From page 8 bodily injury -immediately but not later than two hours after forming the suspicion. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee(s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee(s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21985		