

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2GQS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00667

<p>1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245420</p> <p>2. STATE VENDOR OR MEDICAID NO. (L2) 696519900</p>	<p>3. NAME AND ADDRESS OF FACILITY (L3) LAKWOOD HEALTH SYSTEM (L4) 401 PRAIRIE AVENUE NORTHEAST (L5) STAPLES, MN (L6) 56479</p>	<p>4. TYPE OF ACTION: <u>7</u> (L8)</p> <table style="width:100%;"> <tr> <td>1. Initial</td> <td>2. Recertification</td> </tr> <tr> <td>3. Termination</td> <td>4. CHOW</td> </tr> <tr> <td>5. Validation</td> <td>6. Complaint</td> </tr> <tr> <td>7. On-Site Visit</td> <td>9. Other</td> </tr> </table> <p>8. Full Survey After Complaint</p>	1. Initial	2. Recertification	3. Termination	4. CHOW	5. Validation	6. Complaint	7. On-Site Visit	9. Other							
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<p>5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)</p> <p>6. DATE OF SURVEY 03/20/2015 (L34)</p> <p>8. ACCREDITATION STATUS: ___ (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other</p>	<p>7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE</p>	<p>FISCAL YEAR ENDING DATE: (L35) 12/31</p>															
<p>11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :</p> <p>12. Total Facility Beds 100 (L18)</p> <p>13. Total Certified Beds 100 (L17)</p>	<p>10. THE FACILITY IS CERTIFIED AS:</p> <p>X A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements: _____</u> Program Requirements ___ 2. Technical Personnel ___ 6. Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN ___ 7. Medical Director ___ 1. Acceptable POC ___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size ___ 5. Life Safety Code ___ 9. Beds/Room</p> <p>B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)</p>																
<p>14. LTC CERTIFIED BED BREAKDOWN</p> <table style="width:100%; text-align: center;"> <tr> <td>18 SNF</td> <td>18/19 SNF</td> <td>19 SNF</td> <td>ICF</td> <td>IID</td> </tr> <tr> <td></td> <td>100</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(L37)</td> <td>(L38)</td> <td>(L39)</td> <td>(L42)</td> <td>(L43)</td> </tr> </table>		18 SNF	18/19 SNF	19 SNF	ICF	IID		100				(L37)	(L38)	(L39)	(L42)	(L43)	<p>15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)</p>
18 SNF	18/19 SNF	19 SNF	ICF	IID													
	100																
(L37)	(L38)	(L39)	(L42)	(L43)													
<p>16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):</p>																	
<p>17. SURVEYOR SIGNATURE <u>James Anderson, DSFM</u> (L19)</p>	<p>Date : 03/16/2015</p>	<p>18. STATE SURVEY AGENCY APPROVAL <u>Kate JohnsTon, Program Specialist</u> (L20)</p>															

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

<p>19. DETERMINATION OF ELIGIBILITY <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible (L21)</p>	<p>20. COMPLIANCE WITH CIVIL RIGHTS ACT:</p>	<p>21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____</p>
<p>22. ORIGINAL DATE OF PARTICIPATION 02/01/1987 (L24)</p>	<p>23. LTC AGREEMENT BEGINNING DATE (L41)</p>	<p>24. LTC AGREEMENT ENDING DATE (L25)</p>
<p>25. LTC EXTENSION DATE: (L27)</p>	<p>27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)</p>	
<p>28. TERMINATION DATE:</p>	<p>29. INTERMEDIARY/CARRIER NO. 03001 (L28)</p>	<p>30. REMARKS (L31)</p>
<p>31. RO RECEIPT OF CMS-1539 (L32)</p>	<p>32. DETERMINATION OF APPROVAL DATE 03/24/2015 (L33)</p>	
<p>DETERMINATION APPROVAL</p>		



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245420

June 9, 2015

Mr. Tim Rice, Administrator
Lakewood Health System
401 Prairie Avenue Northeast
Staples, Minnesota 56479

Dear Mr. Rice:

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 March 6, 2015 the above facility is certified for or recommended for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 skilled nursing facility beds located in rooms.

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

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

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Kate JohnsTon". The signature is written in a cursive style with a long, sweeping underline.

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 9, 2015

Mr. Tim Rice, Administrator
Lakewood Health System
401 Prairie Avenue Northeast
Staples, Minnesota 56479

RE: Project Number S5420024

Dear Mr. Rice:

On March 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 20, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 20, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 20, 2015, effective March 6, 2015 and therefore remedies outlined in our letter to you dated March 20, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kate JohnsTon". The signature is fluid and cursive, with the first name "Kate" and last name "JohnsTon" clearly legible.

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245420	(Y2) Multiple Construction A. Building _____ B. Wing NN - LAKEWOOD NURSING HOME	(Y3) Date of Revisit 3/20/2015
Name of Facility LAKEWOOD HEALTH SYSTEM		Street Address, City, State, Zip Code 401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0069	Correction Completed 03/06/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By PS/KJ	Date: 06/09/2015	Signature of Surveyor: 27200	Date: 03/20/2015
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 2/18/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2GQS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00667

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245420		3. NAME AND ADDRESS OF FACILITY (L3) LAKWOOD HEALTH SYSTEM			4. TYPE OF ACTION: <u>2</u> (L8)	
2.STATE VENDOR OR MEDICAID NO. (L2) 696519900		(L4) 401 PRAIRIE AVENUE NORTHEAST			1. Initial 3. Termination 5. Validation 7. On-Site Visit	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)			2. Recertification 4. CHOW 6. Complaint 9. Other	
6. DATE OF SURVEY 02/20/2015 (L34)		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA			8. Full Survey After Complaint	
8. ACCREDITATION STATUS: <u> </u> (L10)		02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF			FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC			12/31	
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE		10.THE FACILITY IS CERTIFIED AS:				
11. LTC PERIOD OF CERTIFICATION		A. In Compliance With <u> </u> And/Or Approved Waivers Of The Following Requirements: <u> </u>				
From (a) :		Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit				
To (b) :		Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director				
12.Total Facility Beds 100 (L18)		<u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size				
13.Total Certified Beds 100 (L17)		<u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room				
14. LTC CERTIFIED BED BREAKDOWN		X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)				
18 SNF 18/19 SNF 19 SNF ICF IID		15. FACILITY MEETS				
100		1861 (e) (1) or 1861 (j) (1): (L15)				
(L37) (L38) (L39) (L42) (L43)						

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

17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY APPROVAL		Date:
<u>Nicolle Marx, HFE NE II</u>		03/16/2015	<u>Kate JohnsTon, Enforcement Specialist</u>		03/20/2015
		(L19)			(L20)

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

19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : <u> </u>	
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25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS			
		A. Suspension of Admissions: (L44)			
		B. Rescind Suspension Date: (L45)			
26. TERMINATION ACTION: (L30)		29. INTERMEDIARY/CARRIER NO. 03001			
VOLUNTARY <u>00</u> INVOLUNTARY		(L28) (L31)			
01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active					
28. TERMINATION DATE:		30. REMARKS			
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)			
		DETERMINATION APPROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 20, 2015

Mr. Tim Rice, Administrator
Lakewood Health System
401 Prairie Avenue Northeast
Staples, Minnesota 56479

****This letter redacts and replaces the letter dated February 24, 2015. It includes the Life Safety Code information.****

RE: Project Number S5420024

Dear Mr. Rice:

On February 20, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

**Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348**

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 1, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 20, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Lakewood Health System

March 20, 2015

Page 6

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245420	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKWOOD HEALTH SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>Lakewood Health System has been found to be in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>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 you acknowledge receipt of the electronic documents.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/2015

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: 245420	(X2) MULTIPLE CONSTRUCTION A. BUILDING NN - LAKEWOOD NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 02/18/2015
NAME OF PROVIDER OR SUPPLIER LAKEWOOD HEALTH SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>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.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lakewood Health System NH was not found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St Paul, MN 55101</p>	K 000			

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
03/06/2015

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.

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

PRINTED: 03/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245420	(X2) MULTIPLE CONSTRUCTION A. BUILDING NN - LAKEWOOD NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 02/18/2015
NAME OF PROVIDER OR SUPPLIER LAKWOOD HEALTH SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 1	K 000		
	<p>Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. <p>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 (111) 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 (111) 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 (111) construction, has been remodeled and part of it is part of the Lakewood Health System Care Center.</p> <p>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.</p>			

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NAME OF PROVIDER OR SUPPLIER LAKWOOD HEALTH SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479		
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K 000	Continued From page 2 The facility has a capacity of 100 beds and had a census of 99 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that 1 of 2 semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 8-3.1 per table 8-3.1, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect residents, all kitchen staff and visitors. Findings Include: On facility tour between 8:30 AM and 11:30 AM on 02/18/2015, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor, the facility failed to provide 1 of 2 service reports showing that the kitchen hood ventilation and fire suppression system has been professionally inspected within the last 12 month time period.	K 069	We had St. Cloud fire equipment co. come in and inspect on 3/5/15 and service this unit. done on 3/5/15 - Jerry Nelson (Maintenance supervisor)	3/6/15	

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NAME OF PROVIDER OR SUPPLIER LAKWOOD HEALTH SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479		
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K 069	Continued From page 3 This deficient practice was verified by the Maintenance Supervisor.	K 069			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 24, 2015

Mr. Tim Rice, Administrator
Lakewood Health System
401 Prairie Avenue Northeast
Staples, Minnesota 56479

Re: Project Number S5420024

Dear Mr. Rice:

The above facility survey was completed on February 20, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston".

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00667	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2015
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NAME OF PROVIDER OR SUPPLIER LAKWOOD HEALTH SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On February 17th, 18th, 19th and 20th surveyors of this Department's staff, visited the above provider and were found to be in compliance with state licencing orders.</p>	2 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/15